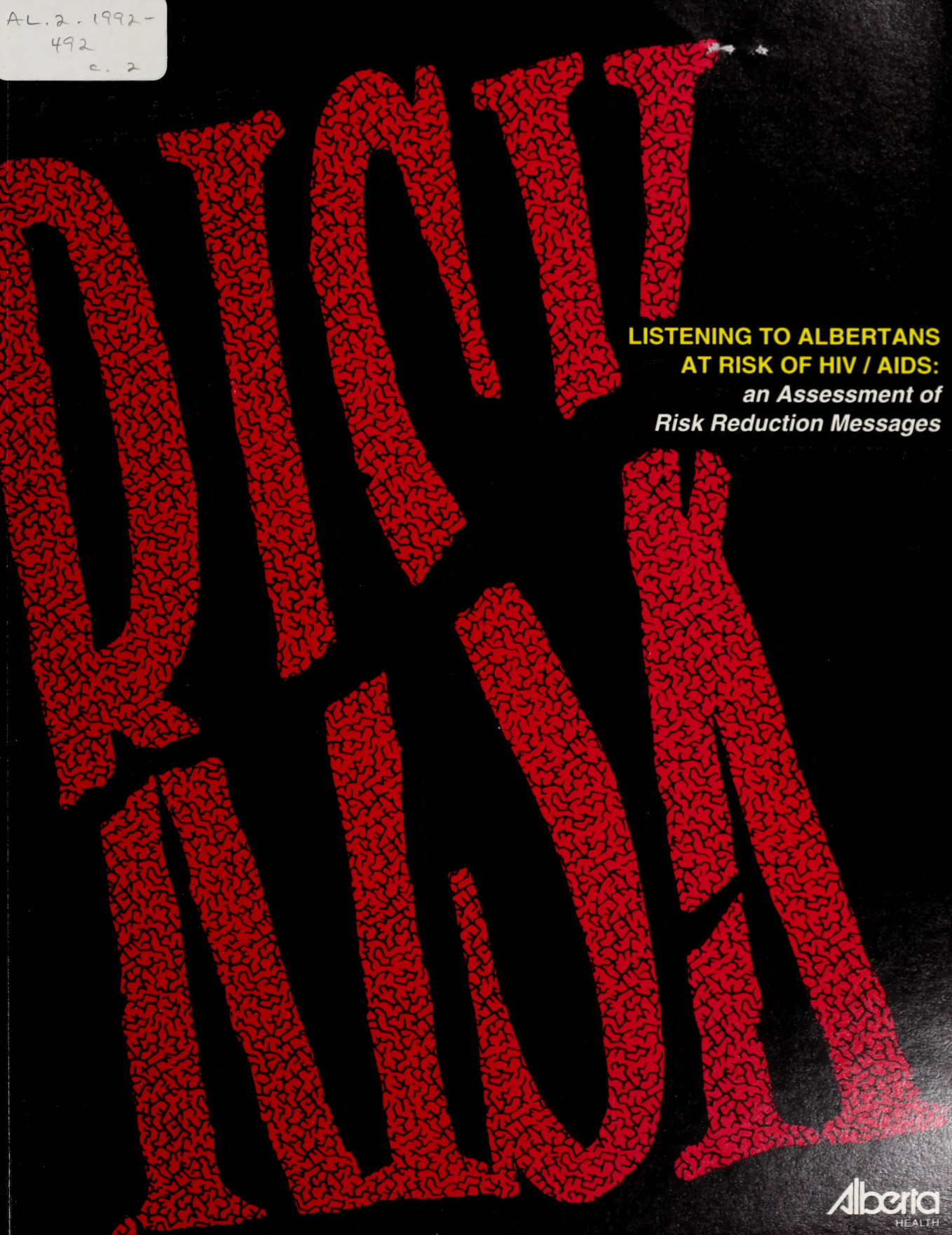


LISTENING TO ALBERTANS AT RISK OF HIV / AIDS:

an Assessment of Risk Reduction Messages

Alberta HEALTH

LISTENING TO ALBERTANS AT RISK OF HIV/AIDS:

AN ASSESSMENT OF RISK REDUCTION MESSAGES

February, 1992

Prepared by

Alberta Management Group
Edmonton, Alberta

Prepared For

The Provincial AIDS Program
Public Health Division
Alberta Health

Copies of:

Listening to Albertans at Risk of HIV/AIDS: An Assessment of Risk Reduction Messages Summary Report
ISBN 0-7732-1033-4

and the full report:

Listening to Albertans at Risk of HIV/AIDS: An Assessment of Risk Reduction Messages Research Report
ISBN 0-7732-1031-8

can be ordered, at no charge, from:

The Provincial AIDS Program
Alberta Health
7th Floor, 10030 - 107 Street
Edmonton, Alberta
T5J 3E4
Phone (403) 427-0836
Fax (403) 422-0914

LISTENING TO ALBERTANS AT RISK OF HIV/AIDS:

AN ASSESSMENT OF RISK REDUCTION MESSAGES

Research Report

February, 1992

ACKNOWLEDGEMENTS

The Alberta Management Group wishes to express its appreciation to members of the Advisory Committee for their advice and guidance during the course of the study. The Advisory Committee consisted of the following individuals:

Mr. Barry Breau
Executive Director
AIDS Network of Edmonton Society

Miss Phyllis Craig
Manager
Provincial AIDS Program
Alberta Health

Dr. David Hewitt
Director
Policy & Program Analysis
Alberta Alcohol and Drug Abuse Commission

Mr. Dan Holinda
Executive Director
AIDS Calgary Awareness Association

Dr. Laurence Jewell
Professor
Department of Pathology
University of Alberta

Dr. Bryce Larke
Medical Director
Provincial AIDS Program
Alberta Health

Mr. Rick McHutchion
Public Information Coordinator
Provincial AIDS Program
Alberta Health

Mr. Keith McLaughlin
Manager, Special Projects
Program Evaluation and Review Branch
Policy & Planning Services
Alberta Health

Dr. Lilly Miedzinski
Director
Division of Infectious Diseases
Department of Medicine
University of Alberta

Dr. Barbara Romanowski
Director
Sexually Transmitted Disease Services
Alberta Health

Ms. Linda Smith
Director
Sexuality Education
Calgary Health Services

Ms. Sharon Thurston
Education Coordinator
AIDS Network of Edmonton Society

Thanks are also extended to the many agencies and private establishments for their cooperation during the data collection phase in permitting access to their clients and patrons.

Finally, we would like to express our sincere gratitude to the many Albertans who so willingly shared their experiences and views about HIV/AIDS risk reduction messages and practices.

TDW
JAC

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

EXECUTIVE SUMMARY

INTRODUCTION

Alberta Health, in concert with a variety of community-based agencies, plays a leading role in coordinating HIV/AIDS education in Alberta. Significant resources have been committed by the Province and community agencies to the design and delivery of messages aimed at assisting people to reduce behaviors that put them at risk of contracting or spreading HIV infection.

A wide variety of approaches to providing risk reduction messages has been employed, although relatively little research has been done in Alberta on the effectiveness of such messages in actually helping people to reduce their risk. Such feedback would be of great value to all agencies in the province involved in reducing the spread of HIV infection by helping them to design better risk reduction messages and related support programs.

With this in mind, the Provincial AIDS Program commissioned a study into HIV/AIDS risk reduction messages in order to learn which approaches are considered effective in helping those at risk to choose safer behaviors. The objectives of the study were to determine:

1. the extent to which risk reduction messages have been received by those who are or have been at risk of becoming infected with HIV or spreading the infection to others;

2. the nature and sources of messages that have been received;

3. the perceived effectiveness or value of those messages in terms of assisting persons who have or have had risky behaviors to select and practice safer behaviors;

4. the factors, where known, which lead to change in behavior or the adoption of safer behavior.

Two methods were used to obtain information for the study:

- **Survey Regarding AIDS Risk Reduction Messages** - a survey of individuals in the province who are or have been at risk was conducted to gather information on the penetration and effectiveness of risk reduction messages;

- **Focus Groups on Risk Reduction Messages** - meetings with different groups of individuals who are or have been at risk were conducted to discuss ways in which risk reduction messages could be improved.

Following is a brief description of each, including principal findings.

SURVEY REGARDING AIDS RISK REDUCTION MESSAGES

Major primary data for the study was obtained through a survey designed to gather information from individuals about their risk behavior and risk reduction practices, their reception and assessment of risk reduction messages, and the barriers they face in practicing risk reduction.

Procedures

Because the study was to focus on the relationship between messages received and reported behavior change in individuals at risk, it was understood that significant methodological challenges would be encountered. Considerable effort went into identification of the target group for the survey and the methods by which data would be collected.

Individuals who were sexually active and/or had injected drugs (key behaviors that would put them at risk of getting or spreading HIV infection if appropriate risk reduction measures were not taken) were recruited from two sources:

- **Service Users** - clients of selected health and social agencies (e.g., STD and birth control clinics, substance abuse treatment centres) who were likely to have engaged in risky behavior;
- **Non-Service Users** - individuals patronizing bars and night spots where socially and sexually active people were likely to gather.

Preliminary focus groups were held and pilot tests conducted to refine the questionnaire and related recruitment procedures. Based on the results, a self-administered questionnaire approach was adopted; in-person interviews and a limited mail-back option were also offered.

Separate field teams were assigned to collect data in each of four locations: Calgary, Edmonton, Grande Prairie, and Lethbridge. Typically, agency clients and bar patrons were approached directly by a researcher to explain the study. Those agreeing to participate were provided a questionnaire to fill out in private, with a team member available to answer questions. The questionnaire was sealed and returned to the researcher when completed.

Response rates depended somewhat on source and location, but were generally high overall. In total, 333 surveys were completed, the majority (91%) by self-administered questionnaire. Almost equal proportions of respondents were obtained from Service and Non-Service User sources.

Principal Findings

The survey revealed a number of important findings relating to risk reduction messages. Principal among these were that:

- awareness of the more basic facts about AIDS and HIV transmission is very high, although some areas of confusion are evident;

- key risk reduction messages are being received by the vast majority of respondents;
- relatively few respondents are having difficulty understanding the information they have received;
- messages have generally been found helpful by the majority of those who received them.

While the vast majority of respondents reported being sexually active, slightly over half had practiced risky sexual behavior in the last five years, 40% within the last 12 months. Proportionately more males reported risky sexual behavior than females. They were also less likely than females to report a reduction in their sexual risk behavior between the two time periods (i.e., in the last 5 years and in the last 12 months). Few respondents (3%) reported engaging in risky injection practices.

The survey also provides some insight into effective themes and sources of messages. Messages that personalize the human tragedy of AIDS, and that impress upon people the scope of the epidemic and "finality" of the disease, tended to elicit a strong emotional response and good message recall. Furthermore, individuals who could recall such a message or experience were more likely to have changed their behavior as a result.

HIV/AIDS information has been received from a wide range of sources. Those most frequently mentioned include:

- the mass media (i.e., TV, radio, newspapers and magazines);
- AIDS print materials;
- public health professionals;
- personal physicians;
- AIDS organizations (especially for homosexual and bisexual respondents); and
- school teachers (especially for those 18 years of age or younger).

While trust levels for these sources was generally very high, homosexual and bisexual respondents were less likely to trust the mass media than others in the sample.

One of the more important purposes of the study was to identify, where possible, behavior changes made as a result of receiving risk reduction messages, and the factors which support or inhibit behavior change. Respondents appeared to be more successful in implementing risk reduction behaviors that required little discussion or negotiation with their partners, for example, *reducing the number of partners they have sex with* and *avoiding getting involved with people who are not concerned about safer sex*. Somewhat fewer, however, reported risk reduction behaviors requiring interpersonal skills, such as *asking about their partner's sexual history*, *practicing other forms of sex that are less risky* and *using condoms all the time*. This result highlights the continued importance of risk reduction messages that impart specific interpersonal skills needed to support risk reduction behavior.

Homosexual and bisexual respondents were most likely to report having made specific changes in their behavior as a result of information about HIV/AIDS, followed by heterosexual females. Heterosexual males were the least likely to report changing their behavior, although they were more likely to report that they were *doing more now than a year ago* (i.e., to be "Recent Changers"). Heterosexual males may be just beginning to implement behavior changes that homosexual and bisexual respondents and heterosexual females started implementing somewhat earlier.

Recent Changers, as a group, were more likely than others to be practicing risky sexual behaviors. They were also more likely to be worried about AIDS; to have seen something about AIDS that really moved or affected them; to have met someone with HIV/AIDS; to have found risk reduction information helpful; and to want more information about HIV/AIDS. These findings provide insight into some of the more important factors associated with behavior change.

For the sample as a whole, key barriers to practicing safer sex were found to be:

- being "high" on alcohol or drugs;
- being sexually aroused; and
- dissatisfaction with condoms.

It is interesting that *fear of how their partner would react* to discussions about alternative sexual practices or condom use was less frequently reported than *difficulty in bringing up the subject*, suggesting personal inhibitions are at least as great a barrier as concerns about negative reactions from their partner. Perhaps not surprisingly, those reporting recent risk behavior were more likely than others to experience barriers to risk reduction.

Access to condoms was not identified by respondents as a significant barrier, but use of condoms was, either because condoms were considered less satisfying or because their partners were not cooperative. Since condom use was most frequently mentioned as the single most important thing respondents did to protect themselves, additional effort appears to be required to make condom use more acceptable and erotic; that is, to make condom use a more positive part of the sex act.

Although risk reduction messages are being well received and are viewed as being personally helpful to respondents, the survey results showed that heterosexual males reported higher risk behavior and greater barriers to risk reduction than other respondents. Because more heterosexual males also reported *doing more now than a year ago* to protect themselves from getting or spreading the AIDS virus, they may also now be more receptive to risk reduction campaigns addressing their needs.

FOCUS GROUPS ON RISK REDUCTION MESSAGES

As a follow-up to the survey, six focus groups were conducted to identify themes, sources and approaches for risk reduction messages that would enhance their effectiveness in motivating and supporting behavior change. Two sessions each were held with groups of heterosexual males (Edmonton and Grande Prairie), heterosexual females (Calgary and Lethbridge) and homosexual and bisexual males (Calgary and Edmonton).

Procedures

Participants were again recruited from agencies and bars in order to provide a similar sample to that selected for the survey (i.e., Service Users, Non-Service Users). Individuals were told of the purpose of the group meeting and, if interested in attending, were screened to ensure they had not been in a long-term monogamous relationship (i.e., 5 years or more). A $20 incentive was offered in consideration of their participation. In total, 48 individuals participated in the six sessions.

In contrast to the experience with survey recruitment, individuals (particularly women) were found to be much more reluctant to participate in focus group discussions, and several of those who confirmed that they would participate failed to attend the session.

Principal Findings

Focus group participants provided a wide variety of comments and suggestions about HIV/AIDS messages. The following were more widely agreed upon, or were more strongly emphasized than others:

- **Alcohol** - Every group viewed alcohol as a primary contributor to unsafe sexual behavior. Participants would like to see a hard-hitting campaign aimed at drinking and sex, similar to current drinking and driving campaigns.

- **Personal Feelings of Susceptibility to HIV Infection** - Many participants suggested the need for very strong and direct messages emphasizing that anyone can get HIV/AIDS. The underlying motivator to behavior change among most participants was fear, either for themselves or for their partners. From this came suggestions to create messages that tap into people's emotions and generate a feeling of personal vulnerability.

- **Visibility and Acceptability of Condoms** - Few focus group participants encountered difficulties locating condoms. Most felt, however, that condoms should be more highly visible in order to reduce inhibitions many people have about condoms. Participants strongly associated safer sex with using a condom. They felt that condoms should be made available in as many different locations as possible in the belief that, if people had greater exposure to condoms, they would become more comfortable talking about them and using them.

- **Role of Condoms** - Focus group members suggested that making condoms more visible must go hand-in-hand with a strong advertising campaign promoting a positive image for condoms and condom users. Creative, visual messages that portray condoms as fun and erotic enhancements to sex would be more appealing to group participants than clinical, obscure messages like: "Practice safer sex."

- **Nature of Risk Reduction Messages** - Participants felt strongly that all messages about safer sex and HIV/AIDS should be blunt and realistic. They were clear that messages should not dance around the issue. Appropriate use of humor and eroticism were encouraged.

- **Tailoring Risk Reduction Messages** - Finally, all focus group members stressed how important it is to provide messages that are tailored to different people. Messages should be designed specifically for different age groups, genders, sexual orientations and walks of life. This would include the format of the message, the language, the messenger, and the media.

CONCLUSIONS

Conclusions relating to each of the four key objectives of the study are summarized below.

1. Reception of Risk Reduction Messages

Survey results clearly show that risk reduction information is being received by those who are or have been at risk of HIV infection. Knowledge of most of the basic facts about HIV/AIDS is high, with a few exceptions; reception of key risk reduction messages is also high; relatively few survey respondents were having difficulty understanding the information they received; and most respondents thought more risk reduction information would be personally useful to them.

Focus group participants confirmed these findings but complained about the lack of risk reduction messages tailored specifically to their needs. Messages designed for mass consumption were seen to be too nondescript and generic, and not really addressed to anyone in particular.

It is clear that many people would not be offended by messages that are direct and explicit. To the contrary, they would react favorably to such messages, particularly if the messages were packaged to be relevant to the groups being targeted.

2. Nature and Source of Messages Received

Messages that personalize the human tragedy of AIDS, and which impress people with the scope of the epidemic and the consequences of becoming infected with HIV were most successful in eliciting a strong emotional response and good message recall. Clearly, however,

messages that provide mainly facts are also being received, as awareness of key risk reduction messages and knowledge of basic facts about HIV/AIDS are high.

HIV/AIDS information was received from a wide range of sources, including the *mass media* (TV, radio, newspapers and magazines), *AIDS print materials*, *public health nurses and other professionals*, *personal physicians*, *AIDS organizations*, and *school teachers*. Moreover, trust levels for these sources were very high, with the exception of trust in the mass media by homosexuals and bisexuals.

3. Perceived Effectiveness of Risk Reduction Messages

Survey results showed that HIV/AIDS risk reduction messages were found to be personally helpful by the majority of respondents. Of those who recalled having seen or heard something about AIDS that really moved or affected them, over two-thirds said they had changed their behavior as a result, indicating the particular effectiveness of such themes in bringing about behavior change.

Risk reduction behaviors requiring discussion and negotiation with a partner (e.g., discussing partner's sexual history, practicing other forms of sex that are safer, using condoms) were reported less frequently by survey respondents than those involving purely personal decisions (e.g., reducing the number of sexual partners), suggesting that messages have been somewhat less effective in assisting people with some of the more difficult risk reduction practices involving interpersonal interactions. Risk reduction messages also appear to have been less effective in helping to reduce two key barriers identified in the study, namely:

- difficulties practicing safer sex when "high" on alcohol;
- difficulties with use of condoms (i.e., sex perceived to be less enjoyable, partner not cooperative).

4. Factors Influencing Adoption of Safer Behaviors

Both the survey and focus groups point to two key motivating factors behind decisions to adopt safer behaviors:

- recognition of personal vulnerability, which generates a realistic level of fear, either for oneself or for others who could inadvertently be infected;
- seeing the human tragedy of AIDS, which generates a strong emotional response (e.g., compassion, revulsion) and an incentive to practice safer behaviors.

It appears that HIV/AIDS risk reduction messages must be made "real" to the individual in order to have significant impact on behavior. Fear, despite its negative connotations from a marketing perspective, appears to be an extremely effective motivating factor, provided it can

be generated on a personal level where individuals recognize and accept that their behavior puts them at risk.

Analysis of Recent Changers in the survey (i.e., those who reported doing more now to protect themselves than one year ago) further illustrates some of the key factors which appear to be associated with changes in behavior. Recent Changers, as a group, were more likely than others:

- to be worried about HIV/AIDS;
- to have seen something about HIV/AIDS that really moved or affected them;
- to have met someone with HIV/AIDS;
- to have found HIV/AIDS information helpful; and
- to want more information on various HIV/AIDS topics.

These results highlight important factors in the change process.

RECOMMENDATIONS

Based on study findings and conclusions, the following recommendations are made:

1. That risk reduction messages continue to use a broad range of sources and approaches in recognition of the variety of ways in which individuals acquire information.

2. That the good coverage and high level of trust that most respondents place in the media, community AIDS organizations and AIDS print materials, including brochures, handouts and posters, support continued use of these sources in HIV/AIDS education.

3. That due to the high trust that most respondents place in public health professionals, personal physicians and teachers, greater involvement of these individuals in HIV/AIDS risk reduction education be encouraged.

4. That risk reduction messages portray situations and people representing lifestyle groups within the population with which individuals can more readily identify.

5. That risk reduction messages be designed as much as possible to be:
   - direct and to the point;
   - explicit;
   - illustrative/demonstrative;
   - personally relevant to the lifestyle and environment of the intended recipient.

6. That risk reduction messages stress, where appropriate, the following themes:
   - portrayal of the human tragedy of AIDS, using the personal stories of real people afflicted with the disease;
   - the scope of the epidemic and the consequences of becoming infected with HIV;
   - realistic appraisals of the personal vulnerability of individuals who engage in risky behavior;
   - the risk of inadvertently infecting others.

7. That risk reduction messages focus greater attention on the following key themes:
   - safer sex and the use of alcohol and drugs;
   - eroticizing safer sex practices;
   - interpersonal discussion and negotiation skills, particularly around condom use and alternative sexual practices.

8. That condoms be promoted as a positive enhancement to sexuality, and made as universally accessible as possible.

10. That clearer information be disseminated about the infectiousness of vaginal fluids, semen, pre-ejaculate and other body fluids, and the mechanics of HIV transmission.

PART 1

INTRODUCTION

BACKGROUND AND PURPOSE

STUDY BACKGROUND

The Provincial AIDS Program of Alberta Health was established in 1987. In addition to its own research and information activities, the Provincial AIDS Program works with a variety of community-based organizations, provincial agencies and national programs to coordinate HIV/AIDS prevention, care and treatment programming in Alberta.

Significant resources have been committed world-wide to the design and delivery of preventive information and educational programming aimed at assisting people to reduce behaviors that put them at risk of contracting or spreading HIV infection. Such programming is typically highly purposeful in terms of the sub-populations being targeted and the intent of the risk reduction messages being disseminated[1]. While various approaches and levels of detail have been employed, risk reduction messages frequently comprise one or more of the following:

- factual information about HIV/AIDS and the mechanisms by which the virus is transmitted;
- the effect of HIV on the immune system and information on the progress and treatment of the disease;
- information on HIV antibody testing and the implications of test results;
- factual information about activities that pose a risk of acquiring or spreading HIV infection;
- information on how such activities can be made safer by using protective measures;
- the physical means (e.g., condoms, clean needles) by which risky activities can be made safer;
- information and skills related to alternative practices that are safer;
- information on the skills needed to negotiate safer behaviors between partners.

A wide variety of sources have been used to disseminate risk reduction messages (e.g., mass media, posters/brochures, individual counselling, school system), and a variety of motivational approaches have been employed (e.g., factual information, fear for self, concern for others).

---

[1] The term "risk reduction message" used throughout this document refers broadly to any information or image intended to influence individuals to practice behaviors that are less risky.

Risk reduction messages are designed implicitly or explicitly around an underlying theory about how behavior change can best be effected in the group being targeted. While some studies have been conducted in other jurisdictions on the effectiveness of specific messages in helping people to reduce their risk (see Bibliography in Appendix A), little research has been done to assess the impact of risk reduction messages in Alberta. Such feedback would be of great value to all agencies in the province engaged in efforts to reduce the spread of HIV infection by helping them to design better risk reduction messages and related support programs.

STUDY OBJECTIVES

The Provincial AIDS Program commissioned a study into AIDS risk reduction messages in order to learn which approaches are considered effective in motivating or helping those at risk to choose safer behaviors. The objectives of the study are to determine:

1. the extent to which risk reduction messages are being received by those who are or have been at risk of becoming infected with HIV or spreading the infection to others;

2. the nature and sources of messages that are being received;

3. the perceived effectiveness or value of those messages in terms of assisting persons who have or have had risky behaviors to select and practice safer behaviors;

4. the factors, where known, which lead to change in behavior or the adoption of safer behavior.

Because the study was to focus on the relationship between messages received and reported behavior change in individuals at risk, it was understood that significant methodological challenges would be encountered. As a base for future research, therefore, the study would also provide practical experience in techniques used to locate, recruit and collect information from individuals at risk. To this end, significant effort was dedicated to designing and testing methodological approaches. Appendix A contains a bibliography of articles relevant to recruitment techniques and risk behavior modification from which methodological design concepts were drawn.

An Advisory Committee was appointed in June, 1990 to oversee the project (see Acknowledgement for the list of members). Terms of Reference were developed and the study was initiated in December of 1990.

STUDY APPROACH

Two methods were used to obtain information for the study:

- **A Survey Regarding AIDS Risk Reduction Messages** - a survey of individuals in the province who are or have been at risk of getting or spreading the AIDS virus;

- **Focus Groups on Risk Reduction Messages** - meetings with different groups of individuals who are or have been at risk of getting or spreading the AIDS virus.

Participants in both the survey and focus group components of the study were obtained in about equal proportions from the following sources:

- **Service Users** - clients of selected health and social agencies (e.g., STD and birth control clinics, substance abuse treatment centres) who were likely to have engaged in risky behavior;

- **Non-Service Users** - individuals patronizing bars and night spots where socially and sexually active people were likely to gather.

Four Alberta communities participated in the study: Calgary, Edmonton, Grande Prairie and Lethbridge.

An extended research design and pilot-testing phase was conducted to determine the specific data collection and recruitment strategies used in the study.

The methodology used in conducting the *Survey Regarding AIDS Risk Reduction Messages* is included in the next section of this report (Part 2), along with a description of the socio-demographic profile and risk status of survey respondents, and survey results. Findings from the *Focus Groups on Risk Reduction Messages* are presented in Part 3, followed by *Conclusions and Recommendations* in Part 4.

PART 2

SURVEY REGARDING AIDS RISK REDUCTION MESSAGES

INTRODUCTION

Primary data for the study were obtained through a survey of individuals who had engaged in behaviors that put them at risk of getting or spreading HIV infection. The principal purpose of the survey was to determine which HIV/AIDS risk reduction messages are being received and the usefulness of these messages in helping respondents to practice safer behaviors.

A general survey of the population at large was not desired; rather, the survey was intended to focus primarily on individuals who were (recently or in the past) sexually active and/or had injected drugs -- key behaviors that would put them at risk of getting or spreading HIV infection if appropriate risk reduction measures were not taken. It was felt that much could be learned both from those with current risk behavior as well as from those who had been at risk in the past but had since taken steps to reduce their risk (i.e., "changers").

In assessing the effectiveness of risk reduction messages, it was decided to target individuals who were *likely to have engaged in risky behavior*, regardless of the extent to which HIV infection was currently prevalent in their respective populations. Thus, the study was not intended to focus narrowly on previously identified "high risk groups" such as men who have sex with men, injection drug users, street youth and people in the sex trade. Instead, the strategy used for this survey (see Method below) was to recruit participants directly from locations where individuals who practiced risky sexual and drug injection behaviors were likely to be found. Two sources of potential survey participants were identified:

- selected health and social agencies (sexually transmitted disease and birth control clinics, substance abuse treatment centres, youth drop-in centres, etc.) serving clients who were likely to have engaged in risky behavior -- referred to as *Service Users* in the remainder of the study;

- bars and night spots where socially active individuals gather who may have engaged in risky behavior -- referred to as *Non-Service Users*.

Some potential for overlap between these two sources of survey participants was recognized.

In preparation for the survey, a series of initial focus groups was held to explore the feasibility of alternative techniques for recruiting participants for the study and approaches to survey questions. Draft questionnaires were developed and pilot tested through in-person interviews with clients of selected agencies in Edmonton and Calgary. A second pilot test was conducted with bar patrons to further test recruitment techniques and to explore the feasibility of alternative survey methods, including in-bar, in-person interviews; in-bar, self-administered questionnaires; interviews conducted via a telephone call-back procedure; and a questionnaire mail-back procedure.

The results of the second pilot test indicated that the in-bar, self-administered approach generated the best completion rate, and that a good response rate could be achieved without the need to offer a financial incentive to participants. Consequently, this approach was chosen as the preferred method for data collection in bars. This approach was chosen as the preferred method for surveying agency clients as well, in order that a standardized data collection protocol could be followed as much as possible for both sources of respondents.

The survey was conducted from September 13 to October 30, 1991. In total, 333 individuals completed the survey. Details regarding the instrument and data collection procedures are provided in the next section, followed by a description of the socio-demographic profile and risk status of the sample, and a discussion of results.

METHOD

INSTRUMENT

A questionnaire, entitled *Survey Regarding AIDS Risk Reduction Messages*, was developed specifically for use in this study (see Appendix B). The questionnaire consists of 33 questions designed to determine:

- respondents' socio-demographic profile;
- their personal risk status;
- what they know about AIDS and its transmission;
- what information they have received about HIV/AIDS;
- their assessment of HIV/AIDS information and information sources;
- whether or not the HIV/AIDS information they received caused them to alter their behavior; and
- risk-reducing practices they follow and barriers they face in attempting to reduce their risk.

The initial design of the questionnaire was based on preliminary discussions with four different groups of high risk individuals to identify the range of issues to be included in the survey and the best approach for collecting sensitive information relating to personal behavior. The instrument was subsequently reviewed by the Advisory Committee and finalized prior to use in the field.

SAMPLE

A targeted sampling strategy was used to select individuals who were *likely to have engaged in behaviors that would put them at risk* of getting or spreading HIV infection (specifically, unprotected sexual intercourse or needle sharing). The sample was not randomly selected or otherwise designed to be representative of the population at large. Thus, inferences cannot be made to other populations from the results obtained. The intent of the survey was simply to describe the views and experiences of those who participated in the survey.

Survey participants were recruited in about equal proportions from the following two sources:

- **Service Users** - clients of selected health and social agencies that provide services to individuals who are likely to have engaged in risky behaviors;

- **Non-Service Users** - individuals patronizing bars and night spots where socially and sexually active people are likely to gather.

The survey was conducted in four locations, representing large and small urban settings in the province of Alberta: Calgary, Edmonton, Grande Prairie and Lethbridge.

For the *Service User* sample, the participating agencies in each location were:

- Edmonton
  - AADAC West End Treatment Centre (Opiate Dependency Program)
  - AIDS Network of Edmonton Society
  - Edmonton Board of Health Birth Control Clinic
  - Elizabeth Fry Society
  - Sexually Transmitted Disease Clinic (Alberta Health)
  - Youth Emergency Shelter

- Calgary
  - AADAC Renfrew Recovery Centre
  - AIDS Calgary Awareness Society
  - Calgary Health Services Family Planning Clinic
  - John Howard Society
  - Safe House (youth shelter)
  - Sexually Transmitted Disease Clinic (Alberta Health)

- Grande Prairie
  - AADAC Northern Addictions Centre
  - Cool Aid (youth drop-in centre)
  - Narcotics Anonymous
  - South Peace Health Unit Sexuality Education

- Lethbridge
  - GALA (gay/lesbian awareness)
  - Lethbridge Health Unit Sexual Health Centre
  - Native Life Skills Program
  - YWCA (youth life skills program)

For the *Non-Service User* sample, bars and night spots were selected to represent a broad range of clientele, including the following:

- blue collar/working class
- college/university
- homosexual and bisexual
- professional
- young "party-oriented"

PROCEDURES

Separate research teams were assigned to collect data in each of the four locations (Calgary, Edmonton, Grande Prairie and Lethbridge). Service agency managers and bar owners were approached by letter and in person concerning the purpose of the study and asked if they would participate. Though some refusals were encountered, the majority of agencies and bars approached agreed to participate. In total, 20 agencies (see previous listing) and 16 bars participated in the study.

Data collection procedures for *Service* and *Non-Service Users* (i.e., respondents recruited from agencies and bars respectively) were as follows:

- **Service Users** - A researcher visited each agency to meet with clients, explain the purpose of the study, distribute the survey, and answer questions individual respondents had with any of the survey items. Respondents were given the option of an in-person interview if they preferred. In a few instances, where the researcher could not easily meet with clients directly, surveys were provided to the agency for clients to complete and mail directly back to the research team in pre-addressed and stamped envelopes.

- **Non-Service Users** - A two member (male/female) team visited each bar at a prearranged time, normally in the early evening (between 7 p.m. and 10 p.m.) on a Thursday, Friday or Saturday. Researchers approached patrons at their tables to explain the purpose of the study and seek their participation. Those agreeing to participate were given a survey to fill out. A team member remained available to answer questions individual patrons had about any of the survey items. Patrons were offered an in-person interview if they preferred. The mail-back option was offered on a limited basis if specifically requested.

Interviewers provided an AIDS pamphlet (*AIDS - The Choices and Chances*; Alberta Health) and a card with the telephone number of the *AIDS Information Line* to agency clients and bar patrons who asked specific questions about HIV/AIDS.

RESPONSE RATES

The participation rate of *Service Users* was very high, with few refusals encountered. The participation rate of *Non-Service Users* varied somewhat by type of bar, but was approximately 50% overall (179 completions out of approximately 350 contacts made). Twenty-nine mail-back surveys were handed out and 12 were returned, giving a response rate of 41% for this option. In total, 25 surveys were rejected due to excessive amounts of missing data (*Service Users* - 12, *Non-Service Users* - 13).

A summary of survey completions for each location (excluding rejected questionnaires) is shown in Table 1. The sample is comprised of almost exactly equal proportions of respondents from the *Service* and *Non-Service User* groups. The self-administered option was selected by 91% of the sample, followed by the in-person interview (5%) and mail-back (4%) options. The largest proportion of respondents were from Edmonton (36%), followed by Calgary (29%), Lethbridge (19%) and Grande Prairie (16%).

TABLE 1

SURVEY COMPLETIONS BY SOURCE, TYPE AND CITY

	Calgary	Edmonton	Grande Prairie	Lethbridge	Total
Service Users:					
# of Agencies	6	6	4	4	20
# of Completions:					
Self-Administered	40	47	29	36	152
Interview	1	7	1	4	13
Mail-Back	0	0	0	2	2
Total	41	54	30	42	167
% of Sample	12%	16%	9%	13%	50%
Non-Service Users:					
# of Bars	6	6	3	1	16
# of Completions:					
Self-Administered	44	65	21	21	151
Interview	5	0	0	0	5
Mail-Back	6	1	3	0	10
Total	55	66	24	21	166
% of Sample	17%	20%	7%	6%	50%
Total Completions	96	120	54	63	333
% of Sample	29%	36%	16%	19%	100%

DATA ANALYSIS PROCEDURES

Means and frequencies have been calculated excluding missing data. Missing data for all major questions averaged less than 2%.

SOCIO-DEMOGRAPHIC PROFILE AND RISK STATUS

Although the sample for this study was drawn from two sources, *Service* and *Non-Service Users*, the socio-demographics and risk profile of respondents from these two sources, as shown in the following section, are similar in many respects. Thus, these sources will be combined in later sections of this report, and note will be made of *Service* and *Non-Service Users* only where differences warrant.

It should be noted that the number of respondents within some of the sub-groups is small, and appropriate caution should be used in interpreting findings in such cases. Also, because the sample was not scientifically drawn, generalizations to the population as a whole or to sub-groups within the population cannot be made. Findings are representative only of the respondents who participated in this study.

SOCIO-DEMOGRAPHIC PROFILE

A socio-demographic profile of respondents, analyzed by sample source *(Service* and *Non-Service Users)*, is shown in Table 2. While approximately equal proportions of males (51%) and females (49%) were represented in the sample, there were marginally more males (58%) in the *Non-Service User* group, and more females (56%) in the *Service User* group.

Overall, more females (59%) than males were under 25 years of age. This trend was reversed for those over 25 (45% of whom were females; see Figure 1). The mean age for *Service Users* (25.7) and *Non-Service Users* (27.0) was similar; however, the *Service User* group contained a greater proportion of respondents in the 14 to 18 year age range (32% versus 7%)[2], whereas the *Non-Service User* group contained a greater proportion in the 19 to 35 year age range (81% versus 51%, cumulatively). The age range for *Service* and *Non-Service Users* was 14-57 and 18-52 years, respectively.

While the sample was roughly evenly divided according to education level, the *Service User* group contained a greater proportion of respondents with less than a high school diploma (47% versus 19%), reflecting, in part, the larger proportion of respondents between 14-18 years of age in this group. The *Non-Service User* group contained a greater proportion of respondents with more than a high school diploma (52% versus 32%).

Service and *Non-Service Users* were similar in terms of living situation and type of residence.

[2] A number of the participating agencies had relatively young clients (e.g., birth control clinics, youth shelter), while bar patrons were typically 18 years of age or older, the legal age for entry to bars in Alberta.

TABLE 2

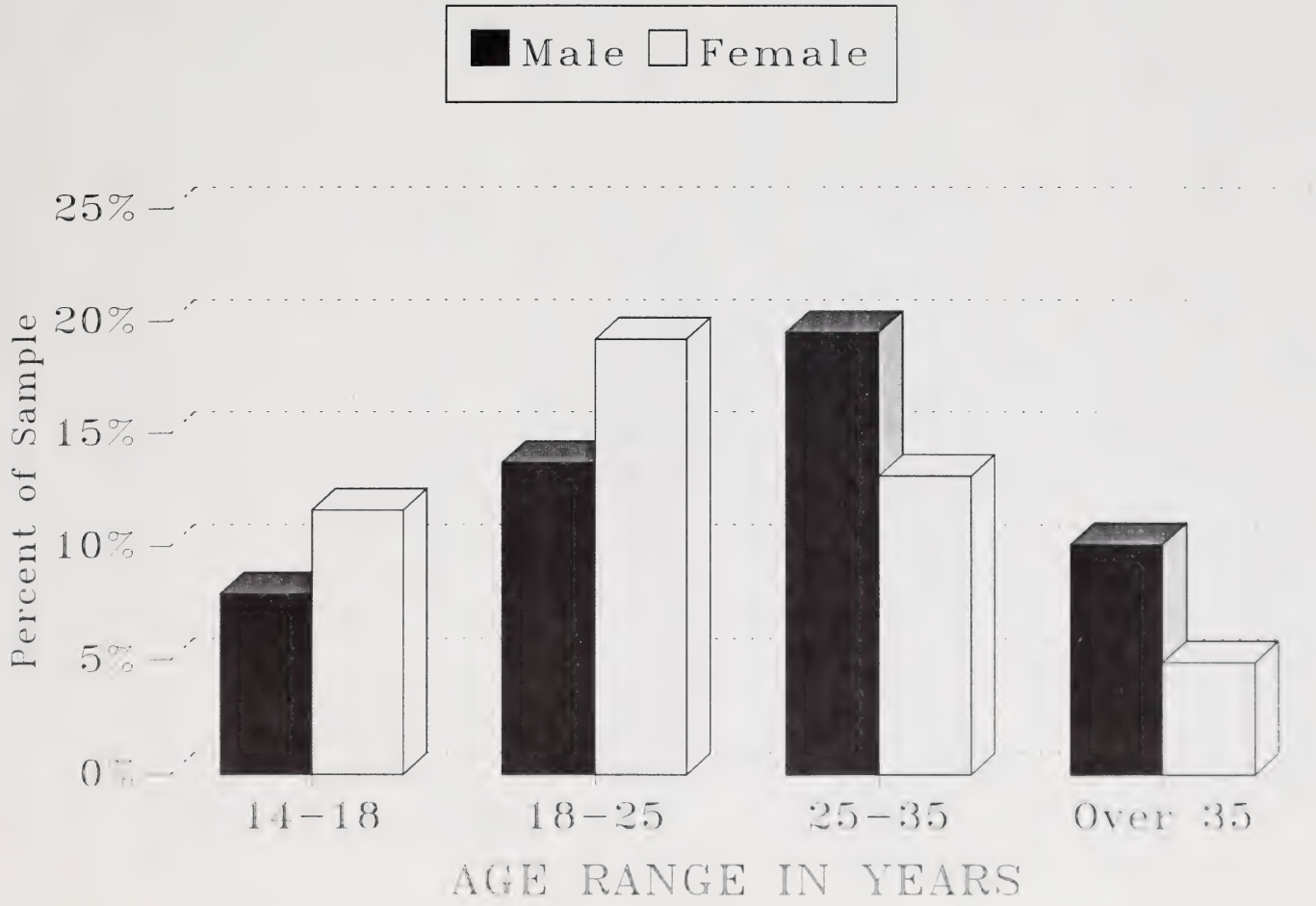
SOCIO-DEMOGRAPHIC PROFILE BY SAMPLE SOURCE

	Service Users (n=167)	Non-Service Users (n=166)	Total (N=333)
Gender:			
Male	44%	58%	51%
Female	56%	42%	49%
Age: (mean)	(25.7)	(27.0)	(26.3)
14 - 18	32%	7%	20%
19 - 25	24%	43%	33%
26 - 35	27%	38%	33%
Over 35	17%	13%	15%
Education:			
Less Than A High School Diploma	47%	19%	33%
High School Diploma	21%	29%	25%
More Than A High School Diploma	32%	52%	42%
Living Situation:			
Alone	20%	27%	23%
Spouse/Partner	27%	25%	26%
Friend(s)	14%	21%	17%
Parent(s)	23%	21%	22%
Group	17%	6%	12%
Residence:			
Public Housing	8%	3%	5%
Rented	55%	61%	58%
Own Home	21%	31%	26%
Hostel/Shelter	8%	1%	5%
Homeless	1%	0%	1%
Other	7%	4%	6%
Financial Support:*			
Full Time Employment	33%	58%	47%
Part Time Employment	20%	17%	19%
Parents	19%	7%	13%
Spouse/Partner	3%	5%	4%
Student Financing	4%	8%	6%
UIC	4%	6%	5%
Social Assistance	22%	7%	15%
Savings	7%	5%	6%
Other	8%	5%	7%
Agency Contact:*			
Community AIDS Organization	20%	18%	19%
Street Program	12%	8%	10%
Birth Control/Family Planning	37%	13%	25%
Alcohol/Drug Treatment	33%	13%	23%
Other	25%	18%	22%

* Percentages do not add to 100% as more than one alternative could be selected.

** Percentages do not add to 100% as contact with each agency was reported independently.

FIGURE 1
AGE BY GENDER



Fewer *Service Users* than *Non-Service Users* were employed full time (33% versus 58%), whereas more were dependent on social assistance (22% versus 7%) or their parents (19% versus 7%) for their principal source of financial support.

As would be expected, *Service Users* had greater contact with agencies in the last year than *Non-Service Users*, particularly with birth control and family planning clinics (37% versus 13%) and with alcohol and drug treatment centres (33% and 13%). The mean number of agencies contacted in the last year by *Service Users* and *Non-Service Users* was 2.4 and 1.3 respectively.

As shown in Table 3, the majority of the sample consists of heterosexual females (93%) and males (76%)[3]. Homosexual and bisexual males (15% and 8%, respectively) were more prevalent overall than homosexual and bisexual females (4% each). Homosexual males were more prevalent among *Non-Service Users* than *Service Users* (20% and 9%). This is likely because gay male bars were specifically targeted for data collection in Edmonton and Calgary, and response rates were high. Due to the small number of bisexual males (14) and females (6) in the sample, bisexuals have been combined with homosexuals in further analyses.

TABLE 3
SEXUAL ORIENTATION AND HIV STATUS
BY SAMPLE SOURCE

	Service Users (n=167)	Non-Service Users (n=166)	Total (N=333)
Sexual Orientation:			
Male	(74)	(96)	(170)
- Heterosexual	84%	71%	76%
- Bisexual	7%	9%	8%
- Homosexual	9%	20%	15%
Female	(93)	(70)	(163)
- Heterosexual	95%	90%	93%
- Bisexual	3%	4%	4%
- Homosexual	2%	6%	4%
***HIV Status**:*			
Tested for HIV	38%	37%	37%
Tested Positive	1%	3%	2%

* Percentages for each variable are based on the total number of respondents per source.

[3] Sexual orientation was determined by the respondent's responses to questions 12.1 through 12.4: *When was the last time you had sex with a female/male; a different female/male* (see Appendix B; *Survey Regarding AIDS Risk Reduction Messages*).

Approximately 37% of the overall sample had been tested for HIV, either specifically (72%) or as part of some other procedure (28%), such as when donating blood or applying for life insurance. The mean number of months since these individuals had last been tested was 11.8 months. Six individuals (approximately 2% of the overall sample) reported being HIV positive: 5 homosexual males and 1 heterosexual female.

Analysis of other sample characteristics showed that *Service Users* were marginally more likely to have previously been surveyed about AIDS than *Non-Service Users* (19% versus 13%), and less likely to have met someone with AIDS or HIV infection (32% versus 46%).

RISK STATUS

Approximately 96% of the sample had been sexually active (as defined by having had sex with a male or female partner) in the last 5 years, and 90% had been sexually active in the last 12 months. Little differences in sexual activity were noted between *Service* and *Non-Service Users* or between males and females. Respondents in the 14 to 18 year age group tended to be somewhat less sexually active in the last 5 years (89%) than other age groups. Respondents in the 14 to 18 (84%) and over 45 (80%) year age groups also tended to be less sexually active in the last 12 months than other age groups.

A number of survey questions asked respondents when they last engaged in specific sexual or drug injection practices, and their use of risk reduction measures in conjunction with those behaviors. Responses to these questions were used to identify those who had practiced risky sexual or injection practices either within the last 12 months or within the last 5 years.

Respondents were considered to have practiced risky sexual behavior during those time periods if they:

- had engaged in any of the following AND did not use condoms all the time:
  - sex with more than one partner,
  - sex with a partner who had other lovers at the time,
  - sex with a partner who injected drugs,
  - sex with a single partner with whom they were not living in a mutually monogamous relationship;

- OR, had had a sexually transmitted disease (including having tested positive for HIV).

Respondents were considered to have practiced risky injection behavior if they injected drugs AND shared the needle (or syringe) without first cleaning it all the time.

Sexual Risk Status

Approximately 54% of the overall sample had practiced risky sexual behavior within the last 5 years, 40% within the last 12 months (see Table 4).

TABLE 4

SEXUAL RISK PROFILE*

Sample Characteristics	---- RISKY SEXUAL BEHAVIOR ---- In Last 5 Years	In Last 12 Months
Total Sample (n=333)	54%	40%
Source:		
Service Users (n=167)	53%	42%
Non-Service Users (n=166)	55%	37%
City:		
Calgary (n=96)	62%	47%
Edmonton (n=120)	55%	38%
Grande Prairie (n=54)	48%	43%
Lethbridge (n=63)	48%	29%
Gender:		
Male (n=170)	54%	42%
Female (n=163)	55%	37%
Age:		
14 - 18 (n=64)	50%	42%
19 - 25 (n=108)	60%	40%
26 - 35 (n=107)	57%	40%
Over 35 (n=49)	47%	39%
Education:		
Less Than High School Diploma (n=108)	52%	42%
High School Diploma (n=81)	61%	46%
More Than High School Diploma (n=135)	55%	36%
Sexual Orientation:		
Male (n=170)		
- Heterosexual (n=130)	52%	43%
- Homosexual/Bisexual (n=40)	63%	40%
Female (n=163)		
- Heterosexual (n=151)	59%	37%
- Homosexual/Bisexual (n=12)	50%	33%
HIV Status:		
Positive (n=6)	100%	33%
Negative (n=107)	52%	38%
Unknown (n=208)	57%	43%

* Percentages are based on the number of respondents for each row variable.

FIGURE 2a

FEMALE RESPONDENTS' SEXUAL RISK STATUS IN EACH AGE RANGE

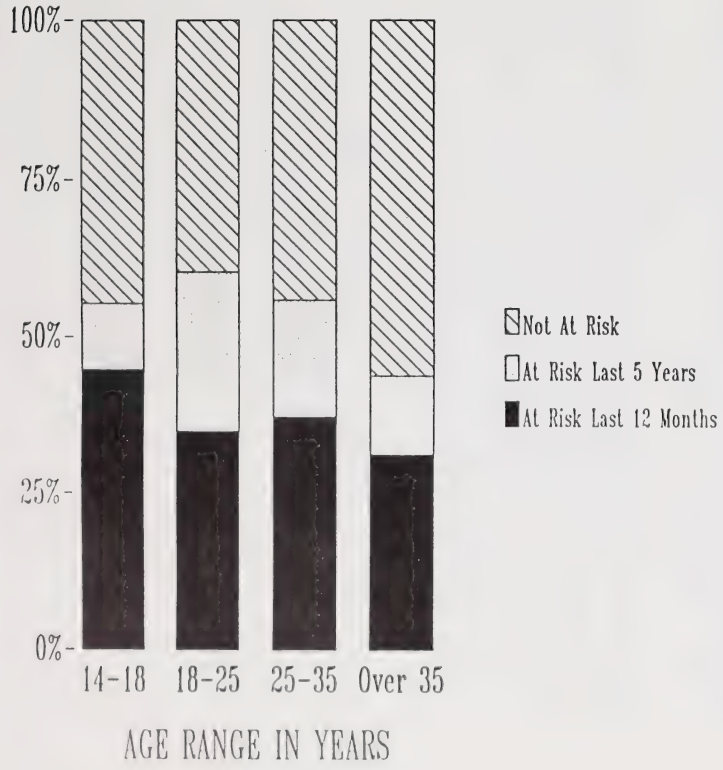
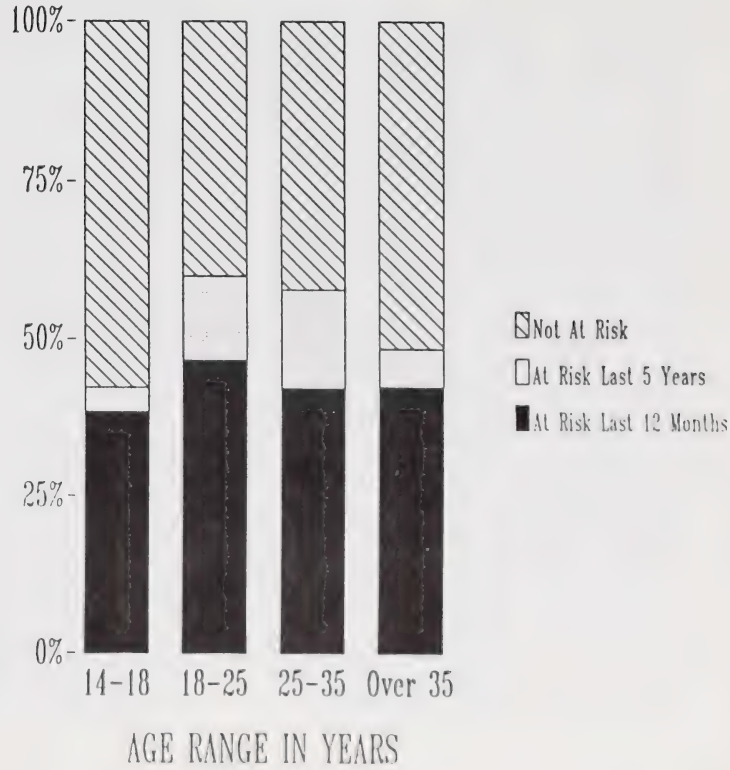


FIGURE 2b

MALE RESPONDENTS' SEXUAL RISK STATUS IN EACH AGE RANGE



As shown in Figures 2a and 2b, proportionately fewer females than males had practiced risky behavior within the last 12 months, relative to the last 5 years, across all age categories. In other words, females, regardless of age, tended to report a greater reduction in risk behavior than males between the two time periods (i.e., in the last 5 years and in the last 12 months).

All individuals who indicated being HIV positive reported risk behavior in the last 5 years; one third (33% - 2 individuals) reported risk behavior in the last twelve months.

It is interesting to compare respondents' self-assessed risk to their sexual risk status as calculated above. Two thirds (66%) of those who felt they were at *little risk* of getting or spreading the AIDS virus had not actually practiced risky sexual behavior in the last 12 months. Similarly, two thirds (67%) of those who considered themselves to be at *considerable risk* had actually practiced risky sexual behavior in the last 12 months. There appears to be some agreement, therefore, between respondents' perceived risk and actual sexual risk status.

Further analysis indicated that those who had practiced risky sexual behavior in the last 12 months, yet who perceived themselves to be *at little risk*, were somewhat less likely to be *very worried* about getting or spreading the AIDS virus (17% versus 28%). In contrast, these respondents were somewhat more likely to want *more information* about HIV/AIDS (23% versus 14%). No other notable differences were found between these respondents and the sample as a whole, including factors such as gender, age, education, sexual orientation, or whether they were drawn from the *Service User* or *Non-Service User* sample.

Injection Risk Status

Forty-four respondents (13% of the total sample; 18% and 8% of the *Service* and *Non-Service User* samples, respectively) reported injecting drugs in the last 5 years, most (71%) of whom had also injected drugs in the last 12 months. Only 3% of the overall sample (or 25% of injection drug users) reported engaging in risky injection practices in the last 5 years, 2% in the last 12 months. That is, the majority (75%) of those who reported injecting drugs indicated either that they never shared their needle and syringe (50%) or that when they did so, they always cleaned it first (25%).

Eight of the 11 respondents who engaged in risky injection practices in the last 5 years also engaged in risky sexual practices.

Sixty-eight percent of injection drug users were *Service Users*, 75% were males, and 74% were over 25 years of age.

RESULTS AND DISCUSSION

FACTUAL AWARENESS

Awareness of basic facts about HIV/AIDS is considered a prerequisite to making informed decisions about risk behavior. Table 5 clearly shows that the vast majority of respondents were aware of many of these facts. For example, over 90% of respondents were aware that AIDS is caused by a virus; that the AIDS virus is spread through sexual contact and by sharing needles; that the proper use of condoms can reduce the spread of HIV/AIDS among sexually active people; and that an infected person can look and feel healthy and have no signs of sickness. Somewhat fewer respondents (80%) were aware, however, that it can take eight or more years before a person who has been infected with the AIDS virus develops AIDS.

Although virtually all respondents were aware that HIV is found in the *blood* of an infected person (97%) and that the virus is spread by contact between infected body fluids and the *vaginal area* (94%), they were less aware that HIV is found in the *pre-ejaculation secretions* (69%), *vaginal secretions* (76%) or *semen* (83%) of an infected person. They were also less aware that the virus is spread by contact between infected body fluids and the *anal area* (87%), *penis* (88%), or *sores or breaks in the skin* (85%). Thus, it would appear that respondents were not as aware of some important facts about HIV transmission as they were about other basic facts, suggesting greater focus may be required on the mechanics of HIV transmission in future messages.

In further exploring awareness levels, an "Awareness Score" was calculated based on the number of facts each respondent was aware of. For example, a respondent aware of all 16 facts listed in Table 5 would receive a score of 16. The mean Awareness Score for the entire sample was 13.8 -- 33% obtained a perfect score, whereas only 4% obtained a score of 50% or less. No reliable differences in mean Awareness Scores were found in relation to gender, age, sexual orientation, level of risky sexual or drug injection practices, or sample source (*Service* versus *Non-Service Users*).[4]

Awareness Scores reliably increased, though not dramatically, with level of education (mean awareness scores were 13.0, 14.2, and 14.0 for those with less than a high school diploma, a high-school diploma, and more than a high school diploma respectively).[5]

---

[4] Mean differences throughout this report were tested using analysis of variance techniques. Statistical reliability was set at $p. \leq .05$.

[5] $F = 6.1$; $df = 2/264$; $p. < .01$.

TABLE 5

AWARENESS OF BASIC FACTS ABOUT HIV/AIDS*

BASIC FACTS:	Percent Aware (N=333)
1) AIDS stands for *Acquired Immune Deficiency Syndrome*	90%
2) AIDS is caused by a virus	91%
3) The AIDS virus is also known as HIV (*Human Immuno-deficiency Virus*)	87%
4) It can take eight or more years before a person who has been infected with the AIDS virus develops AIDS	80%
5) A person infected with the AIDS virus can look and feel healthy, and have no signs of sickness	91%
6) The AIDS virus is spread through sexual contact (primarily vaginal and anal intercourse)	93%
7) The proper use of condoms can reduce the spread of AIDS among sexually active people	97%
8) The AIDS virus is found in the blood of an infected person	97%
9) The AIDS virus is found in the semen of an infected man	83%
10) The AIDS virus is found in the pre-ejaculation secretions of an infected man	69%
11) The AIDS virus is found in the vaginal secretions of an infected women	76%
12) The AIDS virus is spread by contact between infected body fluids and:	
a) the vaginal area	94%
b) the rectal or anal area	87%
c) the penis	88%
d) sores or breaks in the skin	85%
13) The AIDS virus is spread by sharing needles and syringes used for injecting drugs	99%

* A survey question relating to the spread of HIV from infected parents to their (unborn) children was removed from the analysis because the wording was considered to be potentially confusing (see question 1.13 in Appendix B).

KEY RISK REDUCTION MESSAGES

Table 6 lists nine key messages about HIV/AIDS in order of the percent of respondents who heard the message (see "Percent Having Heard" in Table 6). The percent who found the message to be personally helpful, if they had heard it (see "Percent Reporting It Helpful") and those who thought more information on the topic would be personally useful to them (see "Percent Wanting More Info.") are also shown in Table 6.

TABLE 6

RECEPTION AND ASSESSMENT OF KEY RISK REDUCTION MESSAGES

KEY MESSAGE:	Percent Having Heard (N=333)	Percent Reporting It Helpful (N=#Heard)	Percent Wanting More Info. (N=333)
1) How the AIDS virus is spread	99%	94%	59%
2) How some sexual activities can be made safer by using condoms	98%	93%	61%
3) Sexual activities that are risky for getting or spreading the AIDS virus	94%	91%	64%
4) How to convince your partner to use condoms	93%	78%	59%
5) How likely it is for an infected mother or father to give the AIDS virus to their offspring	89%	80%	58%
6) Testing for the AIDS virus and what it means if you test positive or negative	90%	77%	69%
7) Different ways of having sex that are safer	84%	67%	68%
8) Safer ways of injecting drugs*	78%	60%	34%
9) Ways to make safer sexual activities more erotic	71%	55%	69%

* Among the 43 respondents who reported injecting drugs within the last five years, 91% heard this message, 77% thought it was helpful, and 56% thought more information on this topic would be useful.

Reception of Messages

Key risk reduction messages have been received by a large majority of respondents. Seven of the nine messages listed in Table 6 had been heard, or were received, by at least 80% of respondents, and the last two messages had been heard by over 70%.

Two of the messages that were received by somewhat fewer respondents, *Different ways of having sex that are safer* (84%) and *Ways to make safer sexual activities more erotic* (71%), were shown through subsequent analysis to be partially related to the respondents' sexual orientation. A greater proportion of homosexual and bisexual respondents (92%) heard about *Different ways of having sex that are safer* than heterosexual males (83%) and females (82%). Similarly, a greater proportion of these respondents (85%) heard about *Ways to make safer sexual activities more erotic* than heterosexual males (77%) and females (62%). These differences likely reflect the impact of specific HIV/AIDS prevention activities that currently are more predominant in the gay community, such as safer sex workshops and posters which emphasize eroticizing safer sex practices and ways of having sex that are safer.

Although only 78% of respondents heard about *Safer ways of injecting drugs*, 91% of injection drug users, the intended audience for such information, had heard this message (see footnote to Table 6).

As with awareness above, a "Heard Score" was calculated based on the number of messages each respondent had heard. Mean Heard Scores were not found to be reliably related to respondents' gender, age, education, sexual orientation, level of risky sexual or drug injection practices, or sample source.

A graphical presentation of the percent of respondents who heard each of the messages listed in Table 6 by *Sexual Risk Status*, *Behavioral Change Status*, *Sexual Orientation*, and *Gender* (heterosexual respondents only), is included in Appendix C, Figures A1 to A4, respectively.

Helpfulness of Messages

Over 90% of respondents reported that messages they had heard about *How the AIDS virus is spread, How some sexual activities can be made safer by using condoms,* and *Sexual activities that are risky for getting and spreading the AIDS virus* were personally helpful to them. Three other messages were reported to be personally helpful by over three-quarters of the respondents who heard them: *Testing for the AIDS virus, How to convince your partner to use condoms,* and *How likely it is for an infected mother or father to give the AIDS virus to their offspring.*

The three messages that respondents found least helpful were: *Different ways of having sex that are safer* (67%); *Safer ways of injecting drugs* (60%); and *Ways to make safer sexual activities more erotic* (55%). As noted previously, the targeting of these messages to specific audiences largely accounts for these differences. More homosexual and bisexual respondents (86%) thought information about *Different ways of having sex that are safer* was helpful than

heterosexual males (57%) and females (68%). Similarly, more homosexual and bisexual respondents (71%) thought information about *Ways to make safer sexual activities more erotic* was helpful than heterosexual males (53%) and females (50%).

Respondents who said they were *doing more* now, compared to a year ago, to protect themselves from getting or spreading the AIDS virus were also more likely to find information about *Ways to make safer sexual activities more erotic* helpful (65% versus 47%). These same respondents were also more likely to find information about *How to convince your partner to use condoms* helpful (87% versus 69%).

Seventy-seven percent of respondents who had injected drugs within the last five years had found information about *Safer ways of injecting drugs* helpful (see footnote to Table 6).

Analysis of mean "Helpful Scores," calculated in a manner similar to the "Heard Score" above, failed to reveal reliable differences between respondents' gender, age, education, or level of risky sexual or drug injection practices. The mean Helpful Score was, however, lower for heterosexuals (6.0), particularly male heterosexuals (5.8) than it was for non-heterosexuals (7.0).[6]

A graphical presentation of the percent of respondents who found each of the messages listed in Table 6 helpful to them, according to their *Sexual Risk Status*, *Behavioral Change Status*, *Sexual Orientation*, and *Gender* (heterosexual respondents only), is included in Appendix C, Figures A5 to A8, respectively.

Need for More Information

Most respondents indicated that more information about each of the key messages would be useful to them (see "Percent Wanting More Info." in Table 6). Although only 34% wanted more information about *Safer ways of injecting drugs*, this percentage rose to 56% among injection drug users, the intended audience for this message (see footnote to Table 6).

It is interesting to note that although over 90% of respondents thought information about *How the AIDS virus is spread*, *How some sexual activities can be made safer by using condoms* and *Sexual activities that are risky for getting or spreading the AIDS virus* was helpful to them, less than two-thirds thought more information on these topic would be useful.

In contrast, somewhat over two-thirds thought more information would be useful about *Ways to make safer sexual activities more erotic* and *Different ways of having sex that are safer* -- two of the topics that the fewest respondents had thought helpful. Unlike previous analyses of these two topics, the percentage of respondents who thought more information would be useful were not related to sexual orientation. These results suggest that safer sex messages aimed at both heterosexuals and homosexuals may warrant greater emphasis in future campaigns.

---

[6] $F = 10.3$; $df = 1/329$; $p. < .001$.

Analysis of mean "More Scores," calculated in a manner similar to "Heard and Helpful Scores" above, showed that respondents who said they were *doing more* now, compared to a year ago, to protect themselves from getting or spreading the AIDS virus (i.e., Recent Changers) were also more likely to want more information than those *not doing more* (mean More Scores were 5.8 and 4.9, respectively).[7] There was also a strong tendency for heterosexual females to want more information than heterosexual males (mean More Scores were 5.5 and 4.9, respectively).[8] Thus, it would appear that Recent Changers and heterosexual females have a greater tendency to be information seekers than others in the sample. No other notable differences were found.

A graphical presentation of the percent of respondents who wanted more information about each of the messages listed in Table 6, according to their *Sexual Risk Status*, *Behavioral Change Status*, *Sexual Orientation*, and *Gender* (heterosexual respondents only), is included in Appendix C, Figures A9 to A12, respectively.

Message Comprehension

Clearly, it is important that AIDS information be readily understood by those targeted to receive it. The fact that only 14% of the sample (46 respondents - 19 males, 27 females; not shown in Table 6) indicated that they found any of the information difficult to understand suggests that this prerequisite is being met.

Among those that did find some of the information difficult to understand, the topics most frequently cited as causing difficulty were:

- how the virus is spread (respondents reporting=6);
- how the virus can be spread to offspring (4);
- how to use condoms (3);
- different ways of having sex that are safer (3);
- way to eroticize safer sex (3).

The primary reasons given for why these respondents were having difficulty understanding the above topics was either that they did not have enough information, or that the language used was confusing, too technical or too "medical."

Further analysis of the sample was performed to identify characteristics of those who found some of the information hard to understand versus those that had not indicated this to be a problem. Similar patterns emerged for both males and females:

- more were likely to have *less than a high school diploma* (males - 44% versus 30%; females - 52% versus 37%)

[7] $F = 7.3$; $df = 1/315$; $p. < .005$.

[8] $F = 2.9$; $df = 1/279$; $p. = .09$.

- more were likely to be *very worried* about getting AIDS (males - 53% versus 27%; females - 33% versus 23%)

- more were likely to want *more information* about HIV/AIDS (males - 95% versus 85%; females - 100% versus 90%)

These findings indicate that education level plays an important role in message comprehension, and that the few who were experiencing difficulty understanding risk reduction messages tended to be worried about AIDS and to have a desire for more HIV/AIDS information.

The above findings should be interpreted with caution, however, due to the small number of males (19) and females (27) who found some of the information difficult to understand.

Messages With Impact

In another approach to understanding the effectiveness of HIV/AIDS risk reduction messages, respondents were asked to recall anything they had seen or heard about AIDS that really moved or affected them. A little over half (56%) were able to recall such an experience.

Although respondents reported a very wide variety of experiences, the most frequently cited were:

- a TV show or story about "innocent" people (infants, children or adults) who contracted HIV infection and were dying of AIDS, and the effect this had on their families and friends (n = 43);

- a TV show or documentary about a high profile individual (e.g., Rock Hudson) who died from AIDS (36);

- a TV show or movie (generally) about AIDS (25);

- learning that there is no cure for AIDS, that AIDS is fatal (16);

- knowing someone who has AIDS or who died because of AIDS (11);

- learning how many people may be infected and how widespread the disease is (9).

The above responses indicate that messages which personalize AIDS by showing real people (whether perceived to be "innocent" or otherwise) dealing with the disease elicit strong emotional responses and good message recall. Another significant theme was fear (i.e., learning how widespread the epidemic is and that there is no cure).

Importantly, two-thirds of respondents who reported having an AIDS-related experience that really moved or affected them also said they were currently doing something specifically to protect themselves from getting or spreading the AIDS virus because of that experience. This

suggests that themes of the kind noted above could be used more extensively in future information campaigns.

INFORMATION SOURCES

Table 7 lists a number of information sources and shows the percentage of respondents who both received and trusted information about HIV/AIDS from these sources. The percentage trusting each source is based on those who had received information from that source.

TABLE 7
INFORMATION SOURCES

INFORMATION SOURCE:	Percent Having Received (N=333)	Percent Trusting (N=#Received)
1) Media advertisements about AIDS	84%	83%
2) Newspaper articles	80%	69%
3) AIDS brochures, handouts, posters	77%	94%
4) TV/Radio shows	76%	80%
5) News magazines such as Time, Newsweek, Maclean's etc.	70%	83%
6) Public Health nurses and other professionals	68%	96%
7) Your own physician	56%	92%
8) Friends	52%	66%
9) AIDS organizations	45%	98%
10) School teachers*	41%	83%
11) Tabloids such as The National Enquirer	33%	29%
12) Family members**	27%	71%
13) Gay publications***	26%	80%

* For those 18 years of age or younger, 73% had received information about HIV/AIDS from school teachers and 84% trusted this source.

** Similarly, for those 18 years of age or younger, 43% of had received information about HIV/AIDS from family members and 68% trusted this source.

*** Among homosexual and bisexual respondents, the principal audience for gay publications, 82% had received information about HIV/AIDS from this source and 90% trust this source.

Over two-thirds of respondents had received information about HIV/AIDS from the following sources: *Media advertisements*; *Newspaper articles*; *AIDS brochures, handouts and posters*;

TV and radio shows; *News magazines*; and *Public health nurses and other professionals*. In addition, over two-thirds of homosexual and bisexual respondents had received information about HIV/AIDS from *Gay publications*, the principal audience for this type of publication; and over two-thirds of respondents 18 years of age or younger had received information from *School teachers* (see footnotes to Table 7).

Next most common sources were: *Physicians*, *Friends*, and *AIDS organizations*. Although only 45% of respondents overall reported receiving information about HIV/AIDS from *AIDS organizations*, 80% of homosexual and bisexual respondents had received information from this source. Also of note, females who were *very worried* about getting or spreading the AIDS virus were most likely (74%) to have received information about HIV/AIDS from *Friends*, compared to 52% for the sample as a whole.

Only 33% of respondents overall had received information about HIV/AIDS from *Tabloids*. However, 52% of those 18 years of age or younger and 50% of those who thought their behavior put them at *considerable risk* of getting or spreading the AIDS virus, reported receiving information from this source. These respondents, however, were not more likely to trust information from this source than the sample as a whole.

Only 27% of respondents reported receiving information about HIV/AIDS from *Family members*. Further analysis revealed that this was to some extent a function of age. Forty-three per cent of those 18 years of age or younger reported *Family members* as a source of information about HIV/AIDS versus only 23% for those older.

As shown in Table 7, the vast majority of respondents who had received information about HIV/AIDS from the various sources listed also trusted those sources. The principal exception to this finding was for information about HIV/AIDS in *Tabloids*, where only 29% trusted this source.

While *Public health nurses* and *Physicians* were among the most highly trusted sources of information about HIV/AIDS, they were not among the most commonly reported sources. This finding suggests that greater efforts to involve health and medical professionals in providing risk reduction information may be well received and effective.

Interestingly, homosexual and bisexual respondents were less likely to trust the following information sources than others in the sample:

- *Media ads* (58% versus 83% for the sample overall),
- *Newspaper articles* (28% versus 69%),
- *TV and radio shows* (53% versus 80%),
- *Family members* (50% versus 66%).

No other notable differences were found among respondents in relation to their trust in the various information sources listed.

RISK REDUCTION PRACTICES

Over half (57%) of the respondents reported that the threat of AIDS affected their personal behavior either *some* (36%) or *a lot* (21%). Moreover, almost half (48%) said they were doing *more* to protect themselves now than they were a year ago (i.e., Recent Changers). Only 4% said they were doing *less*; the remainder (48%) said they were doing *about the same*. Clearly, then, many people have made adjustments in their lives in order to protect themselves from getting or spreading the AIDS virus. As noted previously, respondents generally found HIV/AIDS risk reduction messages useful to them in making these adjustments.

Table 8 lists some of the specific areas in which information about HIV/AIDS may have caused changes in behavior and the percent of respondents who reported making such changes.

Eighty-five percent of the 44 injection drug users in the sample reported that information about HIV/AIDS had caused them to *avoid risky injection practices*. Also, 80% of all respondents reported that information about HIV/AIDS had caused them to *generally look after their health better*. This was particularly true of Recent Changers; those who said they were *doing more* (89%), as opposed to *not doing more* (71%), to protect themselves now as compared to a year ago.

Many respondents reported that information about HIV/AIDS caused them to make a number of changes in their sexual life. Seventy-five percent reported that they *reduced the number of sexual partners they have sex with*. This was especially true for homosexuals and bisexuals (87%) and heterosexual females (85%). Also, 75% (85% of heterosexual females) said they *avoid getting involved with people who are not concerned about safer sex*. These are practices an individual can do on their own, requiring little "negotiation" with the sexual partner.

Other more interpersonal behaviors, such as *asking questions about their partner's sexual behavior* (67%), or *practicing other forms of sex that are less risky* (50%) were adopted by fewer respondents, as were using condoms during intercourse either *always* (49%) or *in certain situations* (70%). Homosexual and bisexual respondents were an exception to the above, a large majority of which said they *practice other forms of sex that are less risky* (82% versus 43% for heterosexuals) and *always use condoms* (71% versus 45%).

Few (16%) respondents chose to *abstain from sexual intercourse altogether*.

TABLE 8

BEHAVIOR CHANGES MADE BECAUSE OF AIDS INFORMATION

	N*	Percent Reporting Change
1) Avoid risky drug injection practices.	(44)	85%
2) Generally look after your health better	(313)	80%
3) Reduce the number of partners you have sex with.	(258)	75%
4) Avoid getting involved with people who are not concerned about safer sex.	(280)	75%
5) Avoid situations where you might be more likely to have casual sex.	(273)	71%
6) Use condoms during vaginal or anal intercourse in certain situations.	(257)	70%
7) Ask more questions about your partner's past sexual behavior.	(285)	67%
8) Practice other forms of sex (e.g., mutual masturbation) that are less risky.	(277)	50%
9) Always use condoms during vaginal or anal intercourse.	(283)	49%
10) Change your social or sexual behavior in some other way.	(260)	43%
11) Abstain from sexual intercourse altogether.	(292)	16%

* N = Number of valid responses. Respondents who indicated that the question was "Not applicable", as well as the few who did not respond to the question, are not included. The results shown for risky drug injection practices include only those who reported injection drug use.

The relatively low percent of respondents who reported that HIV/AIDS information had caused them to *always use condoms during sexual intercourse* (49%) was not strongly related to the fact that 24% of the sample lived in a mutually monogamous relationship for at least the last five years, and might not have used condoms except for birth control purposes. The percentages of monogamous (42%) and non-monogamous (51%) respondents who reported that HIV/AIDS information had caused them to *always use condoms* were roughly similar.

Although only 49% of respondents reported that HIV/AIDS information caused them to *always use condoms during vaginal or anal intercourse*, 70% indicated that it caused them to *use condoms in certain situations*.

Further analyses, which are presented graphically in Appendix D, Figures A13 to A16, revealed the following:

- Recent Changers (respondents who reported *doing more now*, compared to a year ago, to protect themselves from getting or spreading the AIDS virus) were more likely to report behavioral changes in each of the areas listed than Non-Recent Changers (those not *doing more now*).

- Heterosexual females were more likely to report behavior changes in each of the areas listed in Table 8 than heterosexual males, except for: *always use condoms during vaginal or anal intercourse*.

- Homosexual and bisexual respondents were more likely than heterosexual males and females to: *reduce the number of partners they have sex with*; *use condoms during sexual intercourse* (either in certain situation or always); *practice other forms of sex that are less risky*; and to have *changed their social or sexual behavior in some other way*.

Thus, it would appear that information about HIV/AIDS has caused more heterosexual females, homosexual and bisexual respondents, and Recent Changers to reduce their risk of getting or spreading HIV infection. Heterosexual males appear to be the only exception.

RECENT CHANGERS

Respondents who reported that they were *doing more* to protect themselves from getting or spreading the AIDS virus now, as compared to a year ago (57% of the sample), have been categorized as Recent Changers. Those reporting that they were doing *about the same* or *less* (43%) have been categorized as Non-Recent Changers.

Interestingly, there was a tendency for more males to report being Recent Changers than females (54% versus 41%); these percentages were 52% and 41% for heterosexual males and females respectively. Moreover, when looking only at respondents with sexual risk behavior in the last 12 months, 61% of males at risk were reported to be Recent Changers, compared to only 45% of females. In contrast, as noted previously, more males than females across all age groups had practiced risky sexual behaviors in the last 12 months, relative to the last 5 years, which indicates a greater reduction in risk behavior among females between the two time periods (see Figures 2a and 2b). Also, as noted previously, more heterosexual females than males reported that they had made a number of behavioral changes in response to information about HIV/AIDS (see also Appendix D, Figure A16).

These latter findings appear to indicate that more female than male respondents have changed their risk behaviors, especially their sexual risk behaviors. Yet more males, particularly those practicing sexually risky behavior in the last 12 months, indicated that they were *doing more*

this year as compared to last to reduce their risk of getting or spreading the AIDS virus; that is, more males, particularly those at risk, were reported to be Recent Changers.

Whether or not this constitutes a contradiction is not entirely clear. Perhaps, many of the male respondents, particularly heterosexual males, were just beginning to protect themselves from getting or spreading the AIDS virus -- a finding that may herald a reduction in risk behavior in the future more similar to that of female respondents. Another explanation could be that some male respondents were more likely than their female counterparts to think that they were doing more to protect themselves than actually was the case.

Apart from these findings, some of the other ways Recent Changers differed from Non-Recent Changers include the following:

- 67% of injection drug users with injection risk in the last 12 months indicated that they were Recent Changers, versus 54% of injection drug users without risk;
- 53% of sexually active people with risk behavior within the last 12 months indicated that they were Recent Changers, versus 44% of sexually active people who had not practiced risky behavior within the last 12 months;
- 56% of those *worried* about AIDS were Recent Changers, versus 31% who were *not very worried*;
- 56% of those who had seen something about AIDS that *really moved or affected* them indicated that they were Recent Changers, versus 38% who had not had such an experience;
- 57% of those who had *met someone with HIV/AIDS* indicated that they were Recent Changers, versus 41% who had not;
- 52% of those who found risk reduction information *helpful* indicated that they were Recent Changers, versus 38% who did not;
- 49% of those who wanted *more information* about HIV/AIDS indicated that they were Recent Changers, versus 36% who did not.

It is interesting to note that roughly equal proportions of those with low and high levels (based on a median split) of contact with agencies in the last 12 months were Recent Changers, suggesting that recent contact with an agency in and of itself is not a factor in motivating or influencing individuals to change their behavior. It is also interesting to note that Recent Changers do not appear to differ in terms of age or education.

BARRIERS TO BEHAVIOR CHANGE

As shown in Table 9, 61% of respondents indicated that *being "high" on alcohol or drugs* is a major obstacle to practicing safer sex. Respondents who practiced sexually risky behaviors in the last 12 months were most likely (74%) to find alcohol and drugs troublesome.

TABLE 9

RISK REDUCTION BARRIERS*

	N**	Percent Agreeing
1) You find it hard to practice safer sex when you're high on alcohol or drugs.	241	61%
2) You find it hard to practice safer sex when you're sexually aroused.	305	51%
3) Condoms are not fun or exciting to use.	272	51%
4) It's hard to convince your partner(s) to clean the needle and syringe before sharing it.	60	40%
5) You find it hard to talk to your partner about other kinds of sex that are safer.	285	39%
6) It's hard to get clean needles and syringes.	96	29%
7) It's hard to bring up the subject of condoms with your partner.	302	26%
8) You're afraid of how your partner will react if you ask him or her to try some other kind of sex that is safer.	283	20%
9) You're afraid of how your partner will react if you ask him or her to use a condom.	299	19%
10) It's hard to get condoms.	320	5%

* Positive statements from the survey have been transposed to the negative for ease of analysis.
** Number of valid responses. Those who responded that they "don't know" or who did not answer the question were not included in calculating the percentages shown.

Being sexually aroused, and *dissatisfaction with condoms* were the next most frequently reported obstacles at 51% each. Again, respondents who practiced risky sexual behaviors in the last 12 months were more likely to find these to be particularly troublesome (69% and 62%, respectively). Heterosexual males (63%) found *dissatisfaction with condoms* particularly troublesome.

Fear of how their partner would react to discussions of *alternative sexual practices* (20%) and *condom use* (19%) does not appear to be as large a barrier as simply finding it hard to bring up the subject of *alternative sex* (39%) and *condom use* (26%). Although heterosexual males and females responded similarly to these statements, finding it hard to bring up the subject of *condom use* was particularly troublesome for those who had practiced risky sexual behaviors in the last 12 months (36%, compared to 26% for the sample as a whole) and for homosexual and bisexuals respondents (31%).

Difficulty negotiating safer *needle sharing* practices (40%), particularly among heterosexual male needle users (63%), appears to be a greater barrier than *access to clean needles* (29%). However, heterosexual female needle users found *access to clean needles* more troublesome than their male counterparts (41% versus 24%, respectively).

Access to condoms does not appear to be a significant problem (5%) among respondents.

A graphical presentation of the percent of respondents who indicated having a problem with each of the risk reduction barriers listed in Table 9, according to their *Sexual Risk Status*, *Behavioral Change Status*, *Sexual Orientation*, and *Gender* (heterosexual respondents only), is included in Appendix E, Figures A17 to A20, respectively.

Another finding relating to risk reduction barriers was that 22% of all respondents reported they were having difficulty putting specific risk reduction measures into practice. Many of the specific kinds of risk reduction measures they were having difficulty with are repeats of the barriers listed in Table 9. The most frequently mentioned problem areas were:

- use of condoms (n = 40);
- how to convince your partner to use condoms (24);
- ways to make safer sex more erotic (11);
- different ways of having sex that are safer (8);
- practicing safer sex generally (6).

The most frequent reasons these respondents gave for having difficulty implementing these measures were:

- sex with condoms not as satisfying (n = 20);
- partner not cooperative regarding condom use (13);
- not enough information or don't know how to implement safer sex practices (11);
- reticence about discussing safer sex with partner (10);
- hard to control my sexual desire (4);
- hard to get clean needles (4).

Some respondents (11%) indicated that they had tried a preventive behavior but gave it up. The most common behaviors tried but given up were:

- use of condoms (n = 16);
- abstaining from sex (5).

These responses again indicate that some people were having difficulty using condoms as a preventive measure, either because condoms were felt to be less satisfying, or because their partners were not cooperative. In view of the fact that condom use was reported most frequently by respondents in another section of the survey as the *single most important thing* they did to protect themselves, additional support to reinforce this behavior appear needed.

Some respondents were also having trouble with alternative sex practices and eroticizing safer sex. These difficulties appear consistent with earlier findings about the greater desire for more information about these topics. Lack of skills or reticence about discussing safer sex also appeared as problems for some, confirming the need for messages that continue addressing these issues.

SUMMARY

Experience with the survey indicates that Albertans who are likely to have practiced risky behaviors relating to HIV/AIDS are very receptive to being surveyed about their risk-related behaviors and the measures they are taking to reduce their risk of getting or spreading the AIDS virus (at least by using the techniques employed in this study). However, in view of the sampling procedures chosen for this study, which did not provide a scientifically selected sample, as well as the relatively small number of respondents within some of the subgroups analyzed, inferences based on these finding should not be generalized to the public at large.

The survey revealed a number of important findings relating to risk reduction messages. Principal among these were that:

- awareness of the more basic facts about AIDS and HIV transmission was very high, although some areas of confusion were evident;
- key risk reduction messages were being received by the vast majority of respondents;
- relatively few respondents were having difficulty understanding the information they had received;
- messages were generally found to be helpful by the majority of those who had received them.

Some respondents were less aware of some of the more technical facts about AIDS, such as the body fluids that contain HIV and the specific mechanisms by which HIV is transmitted. Interestingly, respondents were somewhat less interested in receiving more information about these topics, raising questions about how best to convey the more technical/medical information relating to HIV transmission in future.

There was greater interest, however, in receiving more information on other topics, such as *Different ways of having sex that are safer*, and *Ways to make safer sexual activities more erotic*. Although messages on these topics had not been received by as many respondents, particularly heterosexuals, as some of the other topics, all respondents were interested in more information in these areas. These findings underscore the importance of messages that impart safer sex skills, but pose a challenge to many existing agencies in providing such information because of the sensitive nature of the topics involved.

The survey also provides some insight into effective message themes and sources. Messages that personalize the human tragedy of AIDS, and that impress upon people the scope of the epidemic and "finality" of the disease, tend to elicit a strong emotional response and good message recall. Furthermore, individuals who recalled such a message or experience were more likely to have changed their behavior as a result.

HIV/AIDS information was received through a wide range of sources, particularly through the *mass media* (TV, radio, newspapers and magazines); *AIDS print materials; public health nurses and other professionals, including personal physicians;* and *AIDS organizations*.

Apart from the *mass media*, which they tended to mistrust, homosexual and bisexual respondents were most likely to receive HIV/AIDS information from *Gay publications* and *AIDS organizations*.

Public health professionals, personal physicians and *school teachers* were reported as sources of HIV/AIDS information somewhat less frequently than some of the other sources; however, they enjoyed very high trust levels. This suggests that greater use could be made of these channels in the future.

One of the more important purposes of the study was to identify, where possible, behavior changes made as a result of receiving risk reduction messages, and the factors which support or inhibit behavior change. While the vast majority of respondents reported being sexually active, slightly over half had practiced risky sexual behavior in the last five years, 40% within the last 12 months. Proportionately more males reported risky sexual behavior than females. They were also less likely than females to report a reduction in their sexual risk behavior between the two time periods (i.e., in the last 5 years and in the last 12 months). Few respondents (3%) reported engaging in risky injection practices.

Respondents were generally successful in implementing risk reduction behaviors that required little discussion or negotiation with their partners, for example, *reducing the number of partners they have sex with* and *avoiding getting involved with people who are not concerned about safer sex*. Somewhat fewer respondents reported behaviors requiring interpersonal skills, such as *asking about their partner's sexual history*, *practicing other forms of sex that are less risky* and *using condoms all the time*.

Homosexual and bisexual respondents were most likely to report having made behavior changes as a result of information about HIV/AIDS, followed by heterosexual females. Heterosexual males were the least likely to report changing their behavior in various ways to protect themselves from getting or spreading the AIDS virus, although they reported doing more now than a year ago (i.e., to be Recent Changers) than others. Perhaps heterosexual males may be just starting to implement behavior changes that homosexual and bisexual respondents and heterosexual females started somewhat earlier.

Recent Changers, as a group, were more likely than others to be at risk and to be worried about AIDS. They were also more likely to have seen something about AIDS that really moved or affected them, to have met someone with HIV/AIDS, to have found information helpful, and to want more information about HIV/AIDS. These findings provide insight into some of the important factors associated with behavior change.

Perhaps not surprisingly, those reporting recent risk behavior were also more likely to experience barriers to risk reduction of all kinds. Key barriers to practicing safer sex were *being "high" on alcohol or drugs*, *being sexually aroused* and *dissatisfaction with condoms*. It is interesting that *fear of how their partner would react* to discussions about *alternative sexual practices* or *condom use* was less frequently reported than *difficulty in bringing up the subject*, suggesting personal inhibitions are at least as great a barrier as concerns about negative reactions from their partner.

Availability of condoms was not a significant barrier but *condom use* was, either because condoms were considered less satisfying or because their partners were not cooperative. Since *condom use* was most frequently mentioned as the single most important thing respondents did to protect themselves, additional effort appears to be required to make condom use more acceptable and erotic; that is, to make condom use a more positive part of the sex act.

Although risk reduction messages were being well received and were viewed as being personally helpful to respondents, it would appear that heterosexual males warrant increased attention. For example, in comparing heterosexual males to the sample as a whole:

- fewer found the HIV/AIDS information they had received helpful;
- fewer sought additional information on HIV/AIDS;
- more reported practicing risky behaviors;
- fewer reported practicing risk reduction behaviors, although more reported *doing more now* than a year ago;
- more reported experiencing a variety of barriers to risk reduction.

Because more heterosexual males also reported *doing more now* than a year ago to protect themselves for getting or spreading the AIDS virus, they may also now be more receptive to risk reduction campaigns aimed at their needs.

PART 3

FOCUS GROUPS ON RISK REDUCTION MESSAGES

INTRODUCTION

A series of focus groups was conducted in January, 1992, as follow-up to the *Survey Regarding AIDS Risk Reduction Messages*. The purpose of the focus groups was to discuss participants' experiences with risk reduction messages, and to identify themes, sources and approaches that would enhance the effectiveness of messages in motivating and supporting behavior change.

PARTICIPANTS

Six focus groups in total were conducted in Calgary, Edmonton, Grande Prairie and Lethbridge. Each group was comprised of either heterosexual males, heterosexual females, or homosexual males.[9] Table 10 shows the number of participants by focus group type for each location, and the age distribution of the participants.

TABLE 10
FOCUS GROUP PARTICIPANTS BY LOCATION AND AGE

	Heterosexual Males (n=22)	Heterosexual Females (n=12)	Homosexual Males (n=14)	Total (n=48)
Location:				
- Grande Prairie	9			9
- Edmonton	13		9	22
- Calgary		6	5	11
- Lethbridge		6		6
Age:				
- Range	18-43	20-45	18-56	18-56
- Mean	27.8	33.4	31.4	30.2

PROCEDURES

Participants were recruited from agencies and bars (i.e., *Service Users*, *Non-Service Users*) using recruitment procedures similar to those of the survey. Agency clients and bar patrons were told of the purpose of the group meeting and, if interested in attending, were screened to ensure they had not been in a long-term monogamous relationship (i.e., 5 years or more). Follow-up calls were made prior to the session to confirm attendance. Despite an incentive of $20, which was not offered to survey participants, individuals were considerably less willing

[9] Although some bisexual males may have participated in the male "homosexual" groups, the focus of discussion in these groups was on men who have sex with men. Thus, for ease of presentation, participants in these groups will be referred to as homosexual men.

to participate in focus groups than in the survey. Women appeared to be especially concerned about attending focus group sessions, even though the recruiters were female.

Sessions were held in centrally located public facilities in each city in the evenings from approximately 7:30 to 10:00 p.m. Facilities were specifically chosen so that participants would not feel conspicuous attending the meeting (e.g., public library, hotel meeting room). Two consultants served as facilitators for each meeting. For the heterosexual female groups, one male and one female facilitator were used; two male facilitators were used for the remaining groups.

The agenda for each session was modified slightly to tailor the approach for each group. Participants were asked to fill out a brief questionnaire intended to help them privately examine their own behavior and the barriers they faced in attempting to reduce their risk. The remaining time was spent in group discussion of barriers to risk reduction, the effectiveness of risk reduction messages seen by participants, and alternative approaches that they felt would be more effective.

For the group sessions, HIV/AIDS risk reduction messages were broadly defined to include:

- media messages -- ads, brochures, posters, articles in newspapers and magazines, and on radio and TV, etc.;
- messages conveyed in movies, books and plays about AIDS;
- messages from parents, school, the church, etc.;
- messages that friends and sexual partners give to each other;
- messages conveyed by the presence or absence of condom machines in public places, by stores specializing in the sale of condoms, and by needle exchanges for injection drug users, as examples;
- messages conveyed through a change or lack of change in public health/social policies concerning AIDS.

Each focus group session was taped (with the permission of participants) to aid in documenting and summarizing findings. The results are presented under two major headings:

- **General Findings** - ideas and comments about risk reduction messages common to all three group types (heterosexual males, heterosexual females and homosexual males);
- **Group-Specific Findings** - ideas and comments specific to each group type.

Each section provides information dealing with *motivators of behavior change*, *barriers to practicing safer sex*, *messages and their sources*, and *recommended messages and actions*.

GENERAL FINDINGS

MOTIVATORS OF BEHAVIOR CHANGE

Two major types of events or experiences appeared most influential in initiating a behavior change in many of the focus group participants. The first had to do with when participants first began to realize that their behavior might put them at risk of getting or spreading the AIDS virus. This was evidenced by the following comments made by participants when asked what first caused them to start protecting themselves:

- *Caught an STD, and if you can catch an STD, then you can catch AIDS.*
- *Found out that a lot of women I had slept with and thought were "virginal" had really been sleeping around a lot.*
- *Realized how many people I had been exposed to by just sleeping with a few.* In order to help illustrate this, one participant suggested copying the "I told two friends campaign." For example, "I slept with two friends and they slept with two friends and so on and so on."
- *Saw an ad with a heterosexual girl saying: "I never believed it would happen to me." This made me think that AIDS can happen to anyone, even me.* (This came from a male homosexual participant.)
- *Magic Johnson showed that anyone can get it.*
- *Realized that it wasn't just gays who get AIDS. I didn't want to be associated with the stigma of being gay. People think if you have AIDS, then you must be gay.*
- *Heard the numbers were growing and began to think I might be at risk.*

The second had to do with when respondents first became aware of the personal devastation caused by AIDS. These kinds of messages really seemed to touch participants on a "gut" level, and appeared to play an important role in their decisions to practice safer sex. Some of the comments made were as follows:

- *Saw an AIDS victim on TV. He was just wasting away and I felt disgusted. I didn't want that to happen to me.*
- *Heard about AIDS victims who were rejected by their communities.*
- *Saw young people who were infected.*
- *Heard a man with AIDS speak. He was very practical and down to earth.*

- *Saw a story about a family with hemophiliac children who were all infected and how they were run out of town. Found this to be very upsetting.*

- *Heard about a teacher in Nova Scotia who was fired because he was HIV positive.*

These findings are supported by the survey results which also showed the importance of fear and tragic stories in messages that people recalled as having really moved or affected them.

Thus, for most members of the focus groups who had experienced some degree of behavior change, a strong underlying motivator was fear, or at the very least, a sense of vulnerability. Importantly, some of the heterosexual and homosexual men not only felt fear for themselves, they also expressed a strong fear of unknowingly passing the virus to someone else, of being responsible for infecting their sexual partner(s). A member of the homosexual male group summed this up by suggesting that all people should assume that they are HIV positive and behave accordingly.

Juxtaposed to the fear of infecting others were comments made by some heterosexual males that protection against the AIDS virus (condom use in particular) is more the females' prerogative, not unlike responsibility for protection against pregnancy. In their view the woman is at higher risk than the man and therefore needs to take more precautions than her male partner. A possible reflection of this attitude came from female focus group members who expressed a fear of becoming infected, but did not, on their own accord at least, express a concern over infecting their partners.

It is interest to note here that several focus group members reported that they used blood donor clinics to see if they were HIV positive (a potentially dangerous misuse of this service). They believed that if they didn't receive a call after donating blood, they must not be HIV positive.

BARRIERS TO PRACTICING SAFER SEX

Effects of Alcohol

There was a very strong consensus among all focus group participants that alcohol plays an important role in practicing or maintaining safer sex behavior. They suggested that when intoxicated, their inhibitions are lowered and judgement is impaired. This was when they were more likely to have unprotected sex. These comments support survey findings, reported previously, which showed that "being high" on alcohol or drugs was one of the most frequently mentioned barriers to safer sex.

At every focus group meeting it was emphasized that alcohol and sex often go hand in hand; however, none of the participants could recall seeing any messages that addressed the two issues at the same time. It was suggested that a hard-hitting advertising campaign, similar to the current anti-drug, alcohol and smoking campaigns, be developed to appeal to people when they are not under the influence.

Some examples of effective advertising campaigns were:

- "This is your brain. This is your brain on drugs," which uses the analogy of frying an egg. It was noted that participants thought this ad was very visual and difficult to ignore.

- The anti-drinking and driving campaign that shows two glasses full of alcohol smashing together. Again, it was mentioned that this ad was very visual. It was also suggested that there could be a campaign designed around the "designated condom person" which would mirror the designated driver campaign.

- Taking the anti-smoking campaign, but using the slogan "Be cool, Be smart -- Use condoms."

- It was suggested at several focus group meetings that an advertising campaign be developed around characters such as "Condom Police," for example, showing a Condom Police Officer shining his flashlight into the back seat of a car and asking the lovers if they have their condoms with them; or a "Condom Check Stop" where drivers are waived over and asked to show their condoms. Another suggestion was having Condom Police stationed at the doors in bars handing out condoms to people leaving at the end of the night.

Sense of Invincibility

Another commonly mentioned barrier to practicing safer sex was the "It won't happen to me" attitude. Many participants stressed the importance of convincing people that it can happen to anyone, that this is not just a "gay" disease or a disease that affects I.V. drug users. Participants felt that it was important to get the message across that HIV does not discriminate between males and females, homosexuals and heterosexuals, the young or the old.

Female focus group members suggested that just because a man looks like a "nice guy", there is no guarantee that he has not been infected. Similarly, some women thought it was important to stress the fact that neither short-term monogamous relationships nor recent marriage protect you from HIV. Participants suggested that couples in either of these situations be encouraged to continue to use condoms until they have both been tested for HIV.

Accessibility of Condoms

Some of the women participants pointed out how uncomfortable it is for them to buy condoms in drug stores or other very public places, and how infrequent it is to find condom vending machines in female washrooms. A male focus group member asked "If you do not carry a condom with you, where do you find one late at night after the bar closes?"

For those bars that have condom vending machines in the washrooms, there was a concern that these condoms may be unsafe in that their expiration dates may have passed. Many of the focus group participants were not even aware that condoms had expiration dates on them. There were also some questions raised in regard to the effectiveness of different types of condoms, specifically "novelty" items such as glow in the dark or flavored condoms. Some participants felt that packages of novelty condoms were not clearly labeled as to their effectiveness against HIV. One participant suggested that there should be product standards placed on condoms such that condoms that offered ineffective protection against the AIDS virus would not be allowed on the market.

Thus, although survey results indicated that *It's easy to get condoms*, focus group participants suggested that availability is not the same as accessibility. There was also concern about the fact that not all condoms are effective, and a lack of clear information about which are and are not effective.

Regional Differences

In Lethbridge, female focus group members talked about issues that were specific to the religious influence in that area. Participants in the focus groups from Edmonton, Calgary and Grande Prairie did not mention similar problems.

The Lethbridge area was described by several participants as including a strongly conservative, religious sector; that ignorance and denial of AIDS is common among some members of this sector; and that many residents don't acknowledge pre-marital or extra-marital sex, let alone acknowledge that AIDS could be a problem in their area.

These focus group participants also believed that some of the more dominant religious groups in and around the Lethbridge area think sex education should be left to the church and the family, and that it should not be dealt with publicly -- that messages about HIV/AIDS would only encourage sexual activity and promiscuity. One participant, claimed that pressure from religious leaders could result in a teacher being fired for teaching sex education in school.

Focus group members in Lethbridge saw only one possible solution to this problem: religious leaders needed to be enlightened first before educating the rest of the population.

MESSAGES AND THEIR SOURCES

Print Materials

Most members of the male focus groups felt that pamphlets and brochures are not as effective as other means of conveying information. In their view, most people don't take the time to read anymore. Like many other messages they were exposed to every day, they felt that HIV/AIDS messages should be more direct and graphic.

The women, on the other hand, felt that there was still a need for the kind of extensive information that could be provided in a pamphlet. They felt, however, that the messages and information that have been produced to date have not been targeted at women and that many women are still uninformed about HIV/AIDS and their risk of infection. It was also suggested that pamphlets and brochures should be more visual, brighter and more pleasing to the eye.

The survey results suggested that AIDS print materials enjoy both high market penetration and high trust. Focus group results confirm the perceived utility of print materials to some, but also point out design shortcomings that could limit their effectiveness.

For example, "clean" or "sterile" messages were viewed as ineffective because they arouse no interest or curiosity. These messages were seen by focus group members as being too conservative for people who have high risk behaviors. They felt that lectures by authority figures and polite, intellectual statements about practicing safer sex probably had little impact on the people who most needed to hear these messages. Participants agreed that messages need to be presented at a more personal, emotional level, and suggested that the messengers should be people they can identify with as well as empathize with. Messages should help people clearly identify that they are at risk of either getting or spreading the AIDS virus.

Specificity of Messages

Generalized statements like "protect yourself", "reduce your risk" and "practice safer sex" were considered to be ineffective by focus group participants because they really don't provide any useful information. They would like to see simple messages that tell them *how* to protect themselves, *how* to reduce their risk and *how* to practice safer sex. Television advertisements that seemed to be, at best, only indirectly related to AIDS prevention were also considered ineffective. Two examples given were: the ad showing arrows being shot at a Trojan shield; and the ad showing a young couple running through the woods. These commercials were seen as comical by some of the participants, and others felt that they were too obscure to have any real influence on behavior.

Statistics that refer to the number of people in Alberta, for example, who have tested positive for HIV or who have AIDS were felt to be too general for people to relate to. Many would rather see more locally relevant statistics that they can identify with, such as, the percentages of people in their schools or communities that have tested positive for HIV. Again, focus group participants stressed the importance of keeping the messages simple and direct.

Strengthening this argument was the dramatic effect that locally relevant "statistics," which were later found to be totally incorrect, had upon members of one of the male heterosexual groups. One member of this group reported that he had heard that a relatively large percentage of students in the high school he used to go to had tested positive for HIV, this was followed by another member reporting a similar "statistic" from his old high school. These "statistics" generated considerable discussion about the seriousness of HIV/AIDS and the need to be particularly vigilant in protecting oneself and others from infection.

Concern was raised by both a female heterosexual group member and a male heterosexual group member about the emphasis the media places on a possible cure for AIDS. It was felt that this message undermines the threat of getting or spreading the AIDS virus, and causes people to be more relaxed about practicing safer sex. Several focus group members also expressed concern about the frequently inaccurate reporting on AIDS in the media. Some members of the male homosexual groups, in particular, felt that sensationalistic news stories about HIV or AIDS hinder public awareness of the relevant issues, and that the media often takes minor bits of information and blows them out of proportion.

These results support survey findings which showed lower trust levels for the mass media, particularly by homosexual men.

RECOMMENDED MESSAGES AND ACTIONS

Topics

Some of the questions raised by focus group members clearly indicate a need for more information about HIV transmission. For example:

- *Does the level of risk during oral sex depend on who is giving and who is receiving?*
- *Does the level of risk increase during a woman's menstrual cycle?*
- *Is there a risk of transmission through saliva?*
- *What about deep kissing versus casual kissing?*
- *Is there a lower risk of transmitting the virus from female to male than from male to female?*
- *How long does it take to test positive for HIV after exposure to the virus?*
- *What is the level of risk of transmission from a dentist?*
- *Just how does the virus get from semen, pre-ejaculation secretions and vaginal fluids into the blood stream?*

These results support survey findings which showed lower awareness levels regarding bodily fluids other than blood that contain the virus, and specific transmission sites. Some participants also wanted more information about the reliability of HIV testing.

Approach and Targeting

Focus group representatives felt very strongly that messages about HIV/AIDS should be open and frank. One representative suggested the use of street talk to "hook" people. The words

"graphic" and "explicit" were often used. Some members felt that messages should have sexual overtones to them, not necessarily pornographic, but certainly erotic. A similar idea was the use of sexual imagery to "market" safer sex, as is currently done with other products such as beer and cars.

Many focus group members felt that tapping into people's emotions would be more effective than a clinical or medical approach. Some suggested using graphic portrayals of the pain of AIDS for its victims and the families of its victims. These findings support the survey which also found such messages to have strong recall.

Each group that took part in the discussions believed that, along with generic messages that are designed for the entire population, more specific messages should be targeted to them. The women felt that there should be messages targeted specifically to them. Similarly, the heterosexual men said that they need their own messages. The same appeal came from the homosexual men, many of whom felt that they were not being included in current messages at all. All three groups also recommended age-appropriate messages. Homosexual male participants in particular were concerned that younger men who have sex with men may not be as informed or worried about HIV/AIDS as their older counterparts.

Condom-Related Messages

For heterosexual male and female participants, the term "safer sex" primarily meant using a condom during sexual intercourse. The homosexual males had a broader perspective of what safer sex was, including forms of sexual gratification other than intercourse. For example, mutual masturbation was felt to be an acceptable alternative to intercourse for the homosexual males; however, it was not acceptable for the heterosexual male participants. Aside from this discrepancy, all of the focus group participants agreed that condoms should be an integral part of sex and should not be brought out at the last moment simply as a protective measure. They also felt that it's not the number of different partners that puts you at risk, it's not practicing safer sex with EACH partner that increases your risk.

Suggestions from participants as to how to incorporate condom use into the regular, socially acceptable behavior of sexually active people can be grouped into two categories: *making condoms more user friendly* and *making condoms more accessible*.

With regard to the first, *making condoms more user friendly*, it was strongly suggested by most focus group participants that condom use be incorporated into sex education classes in schools, starting at the grade school level. They felt that this education should not only include the proper use of condoms during sexual intercourse, but how to make condoms fun, exciting and erotic. There should also be an emphasis placed on alternative methods of practicing safer sex. It was also suggested that sex education classes teach students how to communicate comfortably with their partners about safer sex, and that students of all sexual orientations be given the skills to make safer decisions regarding their sexuality.

It should be noted that most of the focus group participants have been out of the school system for quite some time. Current sexual health education courses already include some of these issues in their curriculum.

Many of the participants believe that a lot of people do not know how to use a condom properly, though they did not acknowledge this as being their problem. Knowledge that condoms can be ineffective when misused, and the embarrassment that can be caused by a lack of knowledge and experience with condoms, was thought to prohibit the use of condoms altogether among some people. Some focus group members felt that public education on condom use was an important component to safer sex messages.

Along with comments that condom ads be more *visible* and *visual*, were suggestions that the ads be more fun and erotic, that condoms should be depicted as a sexual aid rather than simply for protection. It was felt that condoms need to be presented in a more positive light, as an enhancer rather than an inhibitor of sexuality.

Portraying a condom user as being much more attractive and appealing than a non-condom user was another suggested approach. The example given was of drinking and driving ads that portray a drunk as a "slob" and a "loser", and the sober responsible driver as the attractive role model.

Finally, participants agreed that condoms need to be brought out of the closet. They should no longer be thought of as a "dirty joke." They need to be legitimized and marketed as a positive and fun product. It was suggested by another group member that condoms be marketed as a MUST, not a choice. A suggested slogan to go along with this was: "It's no longer an option, it's a matter of life."

With regard to *making condoms more accessible*, it was generally agreed by focus group members that a massive distribution of condoms would be a very positive step in helping people protect themselves from becoming infected with HIV. Not only would this provide easier access to condoms, but it would also heighten public awareness about safer sex and the need to protect oneself and others from HIV. Some participants felt that condoms should be given away free to low-income, youth and street people. Participants felt that not only should condom machines be placed in school washrooms but that condoms should be freely distributed to students.

Participants also provided some very practical and innovative suggestions as to how and where condoms could be distributed or sold to people throughout the province, some of the more novel of which were:

- liquor stores
- peep shows and porn shops
- public washrooms, including female washrooms
- magazines
- hotel rooms: "a complimentary condom sample"

- market "monogrammed condoms"
- condom "six-packs"
- condom "compacts" for women

The male participants felt that bowls of condoms in bars would be a very effective means of distribution, and might possibly be a way to reach people when they are intoxicated. Some of the women, however, felt that they would not be comfortable picking up condoms in such an open and public place.

To convince those who may not want their tax dollars spent on condoms, a focus group member suggested that a simple comparison of the costs of massive condom distribution with the health care costs of an AIDS victim might be enough to change some minds.

Strategies

Finally, some interesting comments and suggestions dealing with safer sex messages more generally were offered by focus group members. Examples include:

- Conduct AIDS awareness workshops in the workplace as part of health and safety programs.
- Encourage businesses and other organizations, like the Alberta Government, to include HIV/AIDS information in employees' pay envelopes.
- Use appropriate humor, for example, in a cartoon strip like "For Better or Worse".
- Put warnings about AIDS on condom packages and syringe and needle packaging.
- Encourage responsibility for the next generation. For example, copy the "Greening the World" campaign.
- AIDS 1-800 numbers should be better advertised.
- Messages need to cross religious and cultural barriers.
- Attack the belief system. Make it socially unacceptable to have unsafe sex or sex without a condom.

MESSENGERS

Participants agreed that AIDS messengers should be chosen specifically for the gender, age and sexual orientation of the intended recipients. Some other suggestions were as follows:

- People who are well known and test positive for HIV convey the message better than others. Magic Johnson was an example given.
- Role models make good spokespersons.
- Use personal stories from athletes, business people, housewives, etc.
- Show healthy people saying "I didn't think I would get it", or show before and after pictures of AIDS victims.
- Use rock stars to appeal to young people.
- Church leaders could help reach the conservative, religious sector of society.
- Major industries such as the tobacco, alcohol, soft drink, and entertainment industries should be encouraged to include safer sex messages in their advertising.
- Families and friends would make good messengers, as would teachers and school counsellors.
- Comic book heros were also mentioned as possible messengers.

GROUP-SPECIFIC FINDINGS

The following section provides findings that were somewhat more unique to each of the three groups.

HOMOSEXUAL MALES

Motivators of Behavior Change

In addition to the two general themes noted earlier (feeling personally vulnerable, and seeing the personal devastation of AIDS), the following are some of the responses given when homosexual group members were asked what helped them to change their behavior and start protecting themselves from HIV:

- The movie "Long-time Companion."
- International posters that depict erotic positive images for both homosexuals and heterosexuals.
- Day Without Art held on World AIDS Day. It created a huge feeling of loss of potential.
- Names Project Quilt. It was an example of the human element of AIDS. It created an intense feeling of grief and loss.

Barriers to Practicing Safer Sex

Most of the homosexual group members felt that self-esteem played a major role in a homosexual man's attitude about safer sex. One suggested "If a person doesn't care about himself, he won't care about other people." Participants felt that the acceptance of homosexuality as a legitimate sexual orientation would increase self-esteem, and this would be reflected by an increase in safer sex practices among homosexual men. It was also suggested that alcohol and drug abuse are tied to self-esteem, and that if self-esteem were raised, there would be less substance abuse and more safer sex practices.

Many participants felt that public ads target two main groups: heterosexuals and I.V. drug users. Homosexual men who also practice high-risk behaviors were seen to be excluded from these messages. (It is interesting to note that a similar complaint came from some members of the heterosexual male group, who felt that current ads are directed toward the homosexual population. Perhaps ads that are more "generic" in nature tend to be seen by individuals as applying to someone else.)

Sensational news reports were seen by some of the homosexual group members as interfering with and undermining accurate and useful messages. One participant also felt that all the latest

information about HIV or AIDS was not being made available to the public. For example, he noted that alcohol, "poppers," and other substances people use weaken the immune system and this makes the body more susceptible to HIV infection. He felt that this was valuable information and that people should be informed about such things.

Some participants felt that there is a negative attitude about condoms among many homosexual men. Several comments were made about how condoms decrease sensitivity and that they don't feel good. One of the male focus group members suggested that an ad, such as the following, could possibly change this attitude.

> "Sex without condoms is better" -- then show someone who is dying from AIDS -- "Yeah, It's way better isn't it?"

The Nature of Messages

Although fear was generally seen to be a strong motivator of behavior change, some participants were not as convinced. For example, one participant felt that messages such as "If you don't protect yourself, you're going to die" were preaching gloom and doom. He suggested that this made people feel helpless because it doesn't provide any positive information. Following this, another participant suggested that messages be presented as "This is what you CAN do," as opposed to "This is what you SHOULDN'T do." Another felt that serious messages were good but that they should have more of a "subliminal death sentence" approach. For example: "Chances are that if you don't protect yourself, you will come in contact with HIV. It may not be tomorrow or even next year, but it will happen sooner or later."

It was suggested that time and money not be wasted promoting abstinence among homosexual men. Similarly, some participants felt that messages, such as "Reduce the number of partners you have sex with" and "Know your partner's sexual history" could give people a false sense of security. They suggested a simple and straight forward message: "Practice safer sex with EACH partner."

Recommended Messages and Actions

The following suggestions were made by homosexual participants regarding how messages should be formulated and presented to the homosexual population.

- *Use more imagery. This could include visual, audio and moving images.*
- *Build self-esteem among gay men so they care more about protecting themselves. Use the PMA (Positive Mental Attitude) approach. Combine positive messages about being gay with messages about safer sex.*
- *Make the messages blunt and graphic, and put messages in gay bars.*
- *Use peer pressure to encourage condom use.*

- *Promote long-term relationships among homosexual men.*
- *Condom ads should be as common as tampon or feminine protections ads.*
- *Show alternatives to unsafe sex that could be used when neither partner has a condom.*

HETEROSEXUAL MALES

Motivators to Behavior Change

The following are some of the comments made by male heterosexual focus group members when asked what has helped them to change their behavior and protect themselves from HIV:

- *Caring and a feeling of responsibility (the most frequently mentioned motivator).*
- *Using condoms as a form of birth control.*
- *Religion (i.e., pre-marital sex is a sin).*
- *I value my life too much to take risks.*
- *Knew someone with AIDS.*
- *Someone I knew personally and respected told me how dangerous it was to have unsafe sex.*

Barriers to Practicing Safer Sex

The following are some of the specific comments made by male heterosexual focus group members when asked what they thought were barriers to practicing safer sex for heterosexual men like themselves:

- *Getting carried away in the heat of the moment, or as one participant put it, "Letting the wrong head do the thinking" (supporting another survey finding about the difficulties practicing safer sex when sexually aroused).*
- *Being unprepared (i.e., not having a condom when you need one).*
- *Difficulty in changing old habits.*
- *Female partner not wanting to use a condom.*
- *Poor communication with partner regarding condom usage.*

- *Viewing condoms more as a form of birth control than protection. If the woman is on the pill, then condom use is less likely.*

- *Men think women have not slept around a lot. They feel this reduces their risk of infection.*

The Nature of Messages

Some of the members of the male heterosexual groups felt that messages promoting abstinence were unrealistic. This same opinion was expressed by a number of homosexual participants. However, where the homosexual men felt that messages should provide alternatives to sexual intercourse, the heterosexual men felt that these alternatives were also unrealistic. Some of the heterosexual men felt that something like "mutual masturbation" was not an acceptable alternative for most heterosexual men.

Recommended Messages and Actions

In addition to a number of the messages that were common to other groups, heterosexual males provided the following suggestions for AIDS risk reduction messages:

- *Tell people about the risks and how they can deal with their fear.*

- *Show that condoms are effective so that people will be more confident in using them.*

- *Movies and television shows should portray the use of condoms.*

- *Specific messages included the following:*
  - *"You could be next";*
  - *"You have an X% chance of getting AIDS";*
  - *"AIDS can happen to anyone at any time";*
  - *"You could have AIDS";*
  - *"There are no second chances";*
  - *"Every time you have sex, it's like putting a gun to your head with one bullet in it and pulling the trigger";*
  - *"Don't let the wrong head do the thinking";*
  - *"Don't just try --- PRACTICE safer sex";*
  - *Copy the "I told two friends" campaign --- "I slept with two friends and they slept with two friends and so on and so on and so on".*

HETEROSEXUAL FEMALES

Motivators to Behaviour Change

Comments made by female participants suggest similar motivators to those noted by others, for example:

- *Fear of becoming infected.*
- *Hearing a down-to-earth presentation from a person with AIDS.*
- *Hearing about Magic Johnson shows that anyone can get AIDS.*

Other comments indicate the kinds of TV programs and ads that had a strong motivational impact on female participants:

- *The commercial where two women are talking and a condom falls out of one of the women's purse. The women were very sophisticated, well-dressed and self-assured.*
- *Television shows such as "Life Goes On", "ENG" and "AIDS Quarterly".*
- *"Much Music" show using rock stars to educate viewers about HIV/AIDS.*
- *Various "awards" programs showing personalities wearing red ribbons to promote AIDS awareness.*

Barriers to Practicing Safer Sex

The following are some of the specific barriers that female focus group members felt many women face when attempting to practice safer sex:

- *The man might think the woman is promiscuous or, even worse, infected, if she wants to use a condom.* (This attitude was also hinted at by some of the male heterosexuals who suggested that men often believe women have not slept around a lot and therefore their risk of infection from a woman during unprotected sex is greatly reduced.)
- *Condoms decrease sensitivity and reduce spontaneity.*
- *Women are not comfortable experimenting with condoms. They don't know how to make them more fun and erotic.*
- *Many women are unable to suggest to men that they wear condoms.* (One woman felt that this may be a particular problem for very young women and for older women. She thought that perhaps young women had not yet developed a true sense of independence and confidence, and similarly, older women grew up in a time of male dominance. She felt that both age groups might lack the assertiveness to practice safer sex.)

- *Women don't know where to go for information that is specific to them.* (Some group members felt that many doctors were unwilling to talk with women about HIV/AIDS and their level of risk.)

Nature of Messages

Female participants felt that women need to be made to understand that it is primarily their responsibility to protect themselves by carrying and using condoms. It was felt that women need to become more assertive and independent regarding condom use.

It was also suggested that messages targeted towards women should be more emotional. One suggestion was to combine messages about AIDS with a woman's responsibility to and for her children.

Recommended Messages and Actions

A number of female participants believed that women as a whole had been generally neglected when it came to messages about HIV/AIDS, and that this should be corrected. The following are some of the ideas they had:

- *Teach women to be responsible for their own protection. Reassure them that it is acceptable to use condoms and acceptable to say no to sex if their partners don't want to use a condom.*

- *Information and messages should be available in places where women frequent. Some examples are doctors' offices, health clubs, churches, women's organizations, shelters, treatment centers, and women's washrooms.*

- *Air messages on television during soap operas and talk shows.*

- *Market condoms more towards women. An example of Japan was given where condoms are sold door-to-door.*

- *Promote condoms through "infomercials" and sell condoms through a home shopping network.*

- *Provide more family-oriented education.*

- *Make condoms a status symbol for women. For example:*
  - *Show a woman buying condoms with a man standing behind her thinking "Well, here's a women who looks after herself;"*
  - *Show a woman who is initially too embarrassed to buy her own condoms, then later is depicted as an independent woman who freely accesses condoms -- The caption could read "You've come a long way baby;"*
  - *Show a simple message such as "Which is worse? Being embarrassed when buying condoms or dying from AIDS."*

- *Promote an overall healthy lifestyle for women that includes safer sex.*

- *Promote condoms as birth control for women.*

- *Show an attractive woman with the caption: "My definition of a loser is someone who doesn't have a condom at the end of the night."*

- *Develop a campaign around something catchy like: "Candid Condom Comments."*

- *Make up some radio jingles and commercials. For example, change the Aretha Franklin song "Respect Yourself" to "Protect Yourself."*

- *Associate condoms with loving and caring.*

- *Use fear or guilt to reach more conservative parents. For example, "Are you willing to risk your child getting AIDS?" or "Susy, age 15, has just gone on her first date with Johnny. Susy probably won't live to see the age of 19 because Johnny gave her AIDS."*

SUMMARY

Focus group participants provided a wide variety of comments and recommendations in regard to messages about HIV/AIDS. The following are some that were more widely agreed upon or were more strongly emphasized than others.

- **Alcohol** - Every group viewed alcohol as a primary contributor to unsafe sexual behavior. Participants would like to see a hard-hitting campaign aimed at drinking and sex, similar to the current drinking and driving campaign.

- **Personal Feeling of Susceptibility to HIV Infection** - Many participants suggested the need for very strong and direct messages that emphasize that anyone can get AIDS. People need to be made to feel that it is their behavior that puts them at risk, not who they are. The underlying motivator to behavior change among participants was fear. From this they suggested creating messages that tap into people's emotions and messages that generate a feeling of personal vulnerability, using phrases like, "There are no second chances" and "Every time you have unprotected sex, is like putting a gun with one bullet in it to your head (referring to Russian Roulette)." Fear of unknowingly infecting your partner also appeared to be a potential motivator for some.

- **Visibility and Acceptability of Condoms** - Few focus group participants encountered difficulties locating condoms. Most felt, however, that condoms should be more highly visible in order to reduce inhibitions many people have about condoms. Participants strongly associated safer sex with using a condom. They felt that condoms should be given away freely, or at least made available in as many different locations as possible. The assumption was that if people were exposed to condoms on a daily basis, they would become more comfortable with condoms, begin to talk openly about condoms and safer sex, and that this would encourage people to use condoms more.

- **Role of Condoms** - Focus group members suggested that making condoms more accessible must go hand-in-hand with a strong advertising campaign promoting a positive image for condoms and condom users. Creative, visual messages that portray condoms as fun and erotic enhancements to sex would be more appealing to group participants than clinical, obscure messages like: "Practice safer sex." Representatives felt that catchy phrases or jingles that people recognize instantly would help promote condom use. Some of the ads that focus group participants remembered vividly came with phrases like "Wrap that rascal", "Men, use a condom or beat it" and "Don't be iffy, come in a Jiffy" (an ad for Jiffy condoms). One male group member even came up with his own phrase, "Don't let the wrong head do the thinking."

- **Nature of Risk Reduction Messages** - Participants felt strongly that all messages about safer sex and HIV/AIDS should be blunt and realistic. They were clear that messages should not dance around the issue. Appropriate use of humor and eroticism were encouraged.

- **Tailoring Risk Reduction Messages** - Finally, all focus group members stressed how important it is to provide messages that are tailored to different people. Messages should be designed specifically for different age groups, genders, sexual orientations and walks of life. This would include the format of the message, the language, the messenger, and where and when the message is advertised. Many participants thought that good messengers included high-profile men and women, positive role models, as well as average people who have tested positive for HIV or who have AIDS, or who are simply demonstrating responsible behavior.

The primary purpose of the focus groups was to gain insight, from the message recipient's perspective, into effective HIV/AIDS risk reduction messages. Many interesting and innovative suggestions have been discussed above. Appendix F provides a more complete listing of the variety of comments and suggestions documented in the focus group meetings.

PART 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The principal objectives of the study were to determine:

1. the extent to which risk reduction messages are being received by those who are or have been at risk of becoming infected with HIV or spreading the infection to others;

2. the nature and sources of messages that are being received;

3. the perceived effectiveness or value of those messages in terms of assisting persons who have or have had risky behaviors to select and practice safer behaviors;

4. the factors, where known, which lead to change in behavior or the adoption of safer behavior.

Conclusions relating to each of these key objectives are summarized separately below based on the information gathered in the survey and focus group sessions.

RECEPTION OF RISK REDUCTION MESSAGES

Survey results clearly show that risk reduction information is being received by those who are or have been at risk of HIV infection. Knowledge of most of the basic facts about HIV/AIDS is high. The vast majority of respondents understand that HIV causes AIDS and that the virus can be spread through sexual contact or needle sharing. They also understand that HIV transmission can be prevented by using condoms. Somewhat fewer understand some of the more technical facts about HIV/AIDS, for example, the body fluids that contain HIV (with the exception of blood) and some of the specific ways in which HIV is transmitted through contact with these infected body fluids. Focus group sessions also confirmed that there is some confusion around the infectiousness of body fluids other than blood and their role in transmitting HIV.

Reception of key risk reduction messages is also high, and relatively few survey respondents were having difficulty understanding the information they received. Two messages that have not been received by heterosexual respondents to the same extent as homosexual and bisexual respondents are *Different ways of having sex that are safer*, and *Ways to make safer sexual activities more erotic*. Interest in receiving more information on these topics was, however, generally high regardless of sexual orientation.

Although survey findings revealed some evidence of message targeting, many of the focus group participants complained about the lack of risk reduction messages tailored specifically to their needs. Heterosexual female and male focus group participants did not think enough messages had been tailored specifically to them, and several homosexual men believed they had been left out of public education efforts all together. Although risk reduction messages

have, in fact, been tailored to the homosexual community, specifically those marketed through community AIDS organizations and gay publications, for example, the complaint appears to be more related to messages intended for general public viewing; that is, those appearing in the mass media. Here the ads were seen to be too nondescript, too generic, not really addressed to anyone in particular. It is clear that many people would not be offended by messages that are direct and explicit; to the contrary, they would react favorably to such messages, particularly if the messages were packaged to be relevant to the groups being targeted.

NATURE AND SOURCE OF MESSAGES RECEIVED

Both the survey and focus groups pointed to key themes that have been successful in eliciting a strong emotional response and good message recall:

- Messages that personalize the human tragedy of AIDS;
- Messages that impress people with the scope of the epidemic and "finality" of becoming infected with the AIDS virus.

Clearly, however, messages that provide mainly facts and information without overly sensationalizing the issue are being received, since awareness of key risk reduction messages and knowledge of basic facts about HIV/AIDS are high.

Survey results demonstrated the wide range of sources from which HIV/AIDS information is being received. Those most frequently mentioned include the mass media (i.e., TV, radio, newspapers and magazines), AIDS print materials, public health professionals, personal physicians, AIDS organizations (especially for homosexual and bisexual respondents) and school teachers (especially for those 18 years of age or younger). These results point to two important conclusions:

- that the mass media approach has been effective in reaching people with information and will continue to be an extremely important source for risk reduction messages in the future;
- that individuals clearly access multiple sources of information, and therefore a variety of media and sources for risk reduction messages will also continue to be necessary.

While trust levels for key information sources were generally very high, homosexual and bisexual respondents were less likely to trust the media than others in the sample.

Although public health professionals, physicians and teachers were somewhat less frequently cited as sources of HIV/AIDS information than the mass media, for example, the very high trust level respondents had for these sources suggests that greater use could be made of them in the future.

PERCEIVED EFFECTIVENESS OF RISK REDUCTION MESSAGES

Focus group participants provided numerous examples of both effective and ineffective messages which can help to guide the design of future risk reduction campaigns.

Survey results showed that HIV/AIDS risk reduction messages were found to be personally helpful by the majority of respondents, particularly by homosexual and bisexual respondents and heterosexual females. This finding suggests that the information they received assisted them in making decisions relating to risk behavior and risk reduction practices.

Of those respondents who recalled having seen or heard something about AIDS that really moved or affected them, over two-thirds said they had changed their behavior as a result, indicating the particular effectiveness of such themes in bringing about behavior change. The survey also identified specific risk reduction practices that respondents reported as a result of receiving information on HIV/AIDS. Behaviors that involved personal decisions only (e.g., reducing number of partners, avoiding certain people or situations) were reported somewhat more frequently than those requiring interpersonal discussion and negotiation with a partner (e.g., discussing partner's sexual history, practicing other forms of sex that are safer, using condoms). These results suggest that messages have been somewhat less effective in assisting people with some of the more difficult risk reduction practices involving interpersonal interactions.

Risk reduction messages also appear to have been less effective in helping to reduce two key barriers identified in both the survey and focus groups, namely:

- difficulties practicing safer sex when "high" on alcohol;
- difficulties with the use of condoms (i.e., sex perceived to be less enjoyable, partner not cooperative).

FACTORS INFLUENCING ADOPTION OF SAFER BEHAVIORS

Both the survey and focus groups point to two key motivating factors behind decisions to adopt safer behaviors:

- recognition of personal vulnerability which generates a realistic level of fear, either for oneself or for others who could inadvertently be infected;
- seeing the human tragedy of AIDS which generates a strong emotional response (e.g., compassion, revulsion) and an incentive to practice safer behaviors.

Analysis of Recent Changers in the survey (i.e., those who reported doing more now to protect themselves than one year ago) further illustrates the importance of information in the change process, as well as the key motivators discussed above (i.e., fear, moving experience). Recent Changers, as a group, were more likely than others:

- to be worried about AIDS;
- to have seen something about AIDS that really moved or affected them;
- to have met someone with HIV/AIDS;
- to have found HIV/AIDS information helpful; and
- to want more information on various AIDS topics.

It is clear that HIV/AIDS risk reduction messages must be made "real" to the individual in order to have significant impact on behavior. Fear, despite its negative connotations from a marketing perspective, appears to be an extremely effective motivating factor, provided it can be generated on a personal level where individuals recognize and accept that their behavior puts them at risk.

RECOMMENDATIONS

Based on study findings and conclusions, the following recommendations are made:

1. That risk reduction messages continue to use a broad range of sources and approaches in recognition of the variety of ways in which individuals acquire information.

2. That the good coverage and high level of trust that most respondents place in the media, community AIDS organizations and AIDS print materials, including brochures, handouts and posters, support continued use of these sources in HIV/AIDS education.

3. That due to the high trust that most respondents place in public health professionals, personal physicians and teachers, greater involvement of these individuals in HIV/AIDS risk reduction education be encouraged.

4. That risk reduction messages portray situations and people representing lifestyle groups within the population with which individuals can more readily identify.

5. That risk reduction messages be designed as much as possible to be:
   - direct and to the point;
   - explicit;
   - illustrative/demonstrative;
   - personally relevant to the lifestyle and environment of the intended recipient.

6. That risk reduction messages stress, where appropriate, the following themes:
   - portrayal of the human tragedy of AIDS, using the personal stories of real people afflicted with the disease;
   - the scope of the epidemic and the consequences of becoming infected with HIV;
   - realistic appraisals of the personal vulnerability of individuals who engage in risky behavior;
   - the risk of inadvertently infecting others.

7. That risk reduction messages focus greater attention on the following key themes:
   - safer sex and the use of alcohol and drugs;
   - eroticizing safer sex practices;
   - interpersonal discussion and negotiation skills, particularly around condom use and alternative sexual practices.

8. That condoms be promoted as a positive enhancement to sexuality, and made as universally accessible as possible.

10. That clearer information be disseminated about the infectiousness of vaginal fluids, semen, pre-ejaculate and other body fluids, and the mechanics of HIV transmission.

APPENDIX A

BIBLIOGRAPHY

Becker, M.H. & Joseph, J.G. AIDS and Behavioral Change to Reduce Risk: A Review. *American Journal of Public Health*, 1988, *78(4),* 394-410.

Brooks-Gunn, J., Boyer, C. & Hein, K. Preventing HIV Infection and AIDS in Children and Adolescents. *American Psychologist*, 1988, *43(11),* 958-964.

Coxon, A. & Carballo, M. Research on AIDS: Behavioral Perspectives. *AIDS*, 1989, *3(4),* 191-197.

Emmons, C., Joseph, J., Kessler, R., Wortman, C., Montgomery, S. & Ostrow, D. Psychosocial Predictors of Behavior Change in Homosexual Men at Risk for AIDS. *Health Education Quarterly*, 1986, *13(4),* 331-345.

Feldman, D.A. Gay Youth and AIDS. *Journal of Homosexuality*, 1989, *17(1-2),* 185-193.

Huang, K., Watters, J. & Case, P. Psychological Assessment and AIDS Reserch with Intravenous Drug Users: Challenges in Measurement. *Journal of Psychoactive Drugs*, 1988, *20(2),* 191-195.

Joseph, J., Montgomery, C. & Kirscht, J. Perceived Risk of AIDS: Assessing the Behavioral and Psychosocial Consequences in a Cohort of Gay Men. *Journal of Applied Social Psychology*, 1987, *17*, 231-250.

Lamb, G.A. & Leibling, L.G. The Role of Education in AIDS Prevention. *New England Journal of Public Policy*, 1988, *4(1),* 215-222.

Leviton, L.C., Hegedus, A.M. & Kubrin, A. (Eds.), Evaluating AIDS Prevention: Contributions of Multiple Disciplines. In *New Directions for Program Evaluation*. San Francisco: Jossey-Bass Inc., 1990.

Longshore, D. Reaching Populations at Higher Risk for AIDS. *AIDS and Public Policy Journal*, 1989, *4(2),* 101-105.

Lovejoy, N. & Moran, T. Selected AIDS Beliefs, Behaviors and Informational Needs of Homosexual/Bisexual Men with AIDS or ARC. *International Journal of Nursing Studies*, 1988, *25(3),* 207-216.

Melton, G. Ethical and Legal Issues in Research and Intervention. *Journal of Adolescent Health Care*, 1989, *10(3 Supplement*), 36S-44S.

Montgomery, S.B. & Joseph, J.G. Behavioral Change in Homosexual Men at Risk for AIDS: Intervention and Policy Implications. *New England Journal of Public Policy*, 1988, *4(1),* 323-334.

Rugg, D.L., O'Reilly, R.O. & Galavotti, C. AIDS Prevention Evaluation: Conceptual and Methodological Issues. *Evaluation and Program Planning*, 1990, *13*, 79-89.

Siegel, K., Grodsky, P. & Herman, A. AIDS Risk-Reduction Guidelines: A Review and Analysis. *Journal of Community Health*, 1986, *11(4),* 233-343.

Sutton, S.R. Fear-Arousing Communications: A Critical Examination of Theory and Research. In Eiser, J.R. (Ed.), *Social Psychology and Behavioural Medicine*. New York: John Wiley, 1982.

The United States Conference of Mayors. Strategies for Evaluation Design: HIV/AIDS Technical Assistance Sheet. 1988.

Valdiserri, R.O. Evaluating AIDS-Prevention Programs. In *Preventing AIDS: The Design of Effective Programs*. New Brunswick and London: Rutgers University Press, 1989.

APPENDIX B

SURVEY REGARDING AIDS

RISK REDUCTION MESSAGES*

Much has already been done to inform Albertans about AIDS. It is important now to know what information has been received, what the views and experiences of Albertans are about the information they have received, and how they are responding to the threat of AIDS.

The purpose of this survey is to explore these matters and to determine how best to help Albertans check the spread of AIDS.

This study is being conducted by the Alberta Management Group for the Provincial AIDS Program of Alberta Health. If you have any questions or comments regarding this survey, please call 465-3560.

Your candid views and experiences about this important health issue are greatly appreciated.

Questionnaire # _____

---

* The actual survey used in the study was printed as a 10 page, 5½ X 8 in. booklet. It has been reformatted on 8½ X 11 in. paper for inclusion in this report. Some of the space for written responses has been reduced as a result of the reformatting.

Please answer the following questions by placing a check mark (√) for your answer in the space provided.

1. Among OTHER things about AIDS, were you aware that:

		YES	NO
1)	AIDS stands for *Acquired Immune Deficiency Syndrome*?	___1	___2
2)	AIDS is caused by a virus?	___1	___2
3)	The AIDS virus is also known as HIV (*Human Immuno-deficiency Virus*)?	___1	___2
4)	It can take eight or more years before a person who has been infected with the AIDS virus develops AIDS?	___1	___2
5)	A person infected with the AIDS virus can look and feel healthy, and have no signs of sickness?	___1	___2
6)	The AIDS virus is spread through sexual contact (primarily vaginal and anal intercourse)?	___1	___2
7)	The proper use of condoms can reduce the spread of AIDS among sexually active people?	___1	___2
8)	The AIDS virus is found in the blood of an infected person?	___1	___2
9)	The AIDS virus is found in the semen of an infected man?	___1	___2
10)	The AIDS virus is found in the pre-ejaculation secretions of an infected man?	___1	___2
11)	The AIDS virus is found in the vaginal secretions of an infected women?	___1	___2
12)	The AIDS virus is spread by contact between infected body fluids and:		
	a) the vaginal area?	___1	___2
	b) the rectal or anal area?	___1	___2
	c) the penis?	___1	___2
	d) sores or breaks in the skin?	___1	___2
13)	The AIDS virus is spread from infected mothers or fathers to their offspring?	___1	___2
14)	The AIDS virus is spread by sharing needles and syringes used for injecting drugs?	___1	___2

2. Has information about the following been HELPFUL to you personally?

		HELPFUL YES	HELPFUL NO	HAVEN'T HEARD ABOUT THIS
1)	Sexual activities that are risky for getting or spreading the AIDS virus	___1	___2	___3
2)	How some sexual activities can be made safer by using condoms	___1	___2	___3
3)	How to convince your partner to use condoms	___1	___2	___3
4)	Different ways of having sex that are safer	___1	___2	___3
5)	Ways to make safer sexual activities more erotic	___1	___2	___3
6)	Testing for the AIDS virus and what it means if you test positive or negative	___1	___2	___3
7)	How the AIDS virus is spread	___1	___2	___3
8)	How likely it is for an infected mother or father to give the AIDS virus to their offspring	___1	___2	___3
9)	Safer ways of injecting drugs	___1	___2	___3

3. Did you find any of the information HARD TO PUT INTO PRACTICE?

YES ___1
NO ___2
SOME ___3

IF YES OR SOME:

a) What was hard to put into practice? _____

_____

b) Why was it hard to put into practice? _____

_____

4. Did you find any of the information HARD TO UNDERSTAND?

YES ___1
NO ___2
SOME ___3

IF YES OR SOME:

a) What was hard to understand? _____

_____

b) Why was it hard to understand? _____

_____

5. Would MORE information about any of the following be USEFUL to you?

		YES	NO
1)	Sexual activities that are risky for getting or spreading the AIDS virus.	___1	___2
2)	How some sexual activities can be made safer by using condoms.	___1	___2
3)	How to convince your partner to use condoms	___1	___2
4)	Different ways of having sex that are safer.	___1	___2
5)	Ways to make safer sexual activities more erotic.	___1	___2
6)	Testing for the AIDS virus and what it means if you test positive or negative.	___1	___2
7)	How the AIDS virus is spread.	___1	___2
8)	How likely it is for an infected mother or father to give the AIDS virus to their offspring.	___1	___2
9)	Safer ways of injecting drugs.	___1	___2

10) OTHER (*Please specify*) _____

_____

_____

6. The following is a list of information sources about AIDS.
Please indicate if you have RECEIVED AIDS information from these sources, AND if you generally TRUST these sources for AIDS information.

		RECEIVED		TRUST	
		YES	NO	YES	NO
1)	AIDS brochures, handouts, posters?	___1	___2	___1	___2
2)	AIDS organizations?	___1	___2	___1	___2
3)	Family members?	___1	___2	___1	___2
4)	Friends?	___1	___2	___1	___2
5)	Gay publications?	___1	___2	___1	___2
6)	Media advertisements about AIDS?	___1	___2	___1	___2
7)	News magazines such as Time, Newsweek, Maclean's etc?	___1	___2	___1	___2
8)	Newspaper articles?	___1	___2	___1	___2
9)	Public Health nurses and other professionals?	___1	___2	___1	___2
10)	School teachers?	___1	___2	___1	___2
11)	Tabloids such as The National Enquirer, The Star, etc?	___1	___2	___1	___2
12)	TV/Radio shows?	___1	___2	___1	___2
13)	Your own physician?	___1	___2	___1	___2

7. Have you ever met anyone who has AIDS, or who you know is infected with the AIDS virus?

YES ___1
NO ___2
DON'T KNOW ___3

8. How WORRIED are you personally about getting or spreading the AIDS virus?

VERY WORRIED ___1
SOMEWHAT WORRIED ___2
NOT WORRIED ___3

9. How MUCH has the threat of AIDS affected your personal behavior?

VERY LITTLE ___1
SOME ___2
A LOT ___3

10. Has information about the risk of aids CAUSED you to:

		YES	NO	NOT APPLICABLE
1)	Ask more questions about your partner's past sexual behavior?	___1	___2	___3
2)	Reduce the number of partners you have sex with?	___1	___2	___3
3)	Avoid situations where you might be more likely to have casual sex?	___1	___2	___3
4)	Avoid getting involved with people who are not concerned about safer sex?	___1	___2	___3
5)	Abstain from sexual intercourse altogether?	___1	___2	___3
6)	Always use condoms during vaginal or anal intercourse?	___1	___2	___3
7)	Use condoms during vaginal or anal intercourse in certain situations?	___1	___2	___3
8)	Practice other forms of sex (e.g., mutual masturbation) that are less risky?	___1	___2	___3
9)	Generally look after your health better?	___1	___2	___3
10)	Avoid risky drug injection practices?	___1	___2	___3
11)	Change your social or sexual behavior in some OTHER way?	___1	___2	___3

IF YES to item #11 above, please explain:

_____

_____

_____

11. COMPARED TO A YEAR AGO, would you say you are NOW doing more, about the same or less to protect yourself from getting or spreading the AIDS virus?

MORE ___1
ABOUT THE SAME ___2
LESS ___3

The questions on the next few pages are very personal. Your candid answers are needed so that we can better understand the level of risk Albertans are taking with respect to AIDS. Please be assured the information you provide will be kept strictly confidential.

12. When was the LAST time you:

	WITHIN THE LAST 12 MONTHS	WITHIN THE LAST 5 YEARS	MORE THAN 5 YEARS AGO	NEVER
1) had sex with a female?	___1	___2	___3	___4
2) had sex with a different female?	___1	___2	___3	___4
3) had sex with a male?	___1	___2	___3	___4
4) had sex with a different male?	___1	___2	___3	___4
5) had sex with a person who had other lovers at the time?	___1	___2	___3	___4
6) had sex with a person who injects drugs?	___1	___2	___3	___4
7) had a sexually transmitted disease?	___1	___2	___3	___4

13. Have you had VAGINAL intercourse within the last five years?

YES ___1
NO ___2

IF YES:

a) Which of the following describes your CONDOM USE during vaginal intercourse in the last 5 years?

1. ___ Always used condoms
2. ___ Never used condoms
3. ___ Sometimes used condoms (please explain)

b) When you use condoms, do you use them PRIMARILY for birth control OR to protect against AIDS and other sexually transmitted diseases?

1. ___ Birth control
2. ___ AIDS and other sexually transmitted diseases
3. ___ Don't use condoms

c) Have you had vaginal intercourse within the last 12 months?

1. ___ Yes
2. ___ No

14. Have you had ANAL intercourse within the last five years?

YES ___1
NO ___2

IF YES:

a) Which of the following describes your CONDOM USE during anal intercourse in the last 5 years?

1. ___ Always used condoms
2. ___ Never used condoms
3. ___ Sometimes used condoms (please explain)

b) Have you had anal intercourse within the last 12 months?

1. ___ Yes
2. ___ No

15. Have you had ORAL sex within the last five years?

YES ___1
NO ___2

IF YES:

a) Which of the following describes your use of condoms or other protective barriers during oral sex?

1. ___ Always used protection
2. ___ Never used protection
3. ___ Sometimes used protection (please explain)

b) Have you had oral sex within the last 12 months?

1. ___ Yes
2. ___ No

16. Have you INJECTED DRUGS within the last five years?

YES ___1
NO ___2

IF YES:

a) Which of the following describes your NEEDLE USE during the last 5 years?

1. ___ I never share
2. ___ When I shared, I always cleaned the needle and syringe first
3. ___ When I shared, I never cleaned the needle and syringe first
4. ___ When I shared, I sometimes cleaned the needle and syringe first

(please explain)

b) Have you injected drugs within the last 12 months?

1. ___ Yes
2. ___ No

17. Have you ever been TESTED to see if you have been infected with the AIDS virus?

YES ___1
NO ___2

IF YES:

a) Did you specifically request the test or was it for some other reason (e.g., giving blood)?

1. ___ Specific request
2. ___ Some other reason (please specify):

b) Did you test positive or negative?

1. ___ Positive
2. ___ Negative
3. ___ Don't know

c) How many months has it been since you were last tested?

_____ Months

18. Do you do anything SPECIFICALLY to protect yourself from getting or spreading the AIDS virus?

YES ___1
NO ___2

IF YES:

a) What is the SINGLE MOST IMPORTANT THING you do?

_____

_____

b) Where did you LEARN about doing that?

_____

c) If there are certain situations when you DON'T do that, please explain.

_____

d) What are some of the OTHER things you do?

_____

_____

e) What has HELPED you the most to do the things you mentioned in `a' and `d' above?

_____

_____

19. Do you recall hearing or reading anything about AIDS that REALLY MOVED OR AFFECTED you?

YES ___1
NO ___2

IF YES:

a) What was it?

_____

_____

b) Are you doing anything BECAUSE of that to reduce your risk of getting or spreading the AIDS virus ?

1. ___ Yes
2. ___ No

20. Have you TRIED to do some things to protect yourself from getting or spreading the AIDS virus BUT GAVE THEM UP?

YES ___1
NO ___2

IF YES:

a) What were they?

_____

_____

b) Why did you give them up?

21. What do you think would be the best way to get the AIDS message to other people like yourself so that they can better protect themselves from getting or spreading the AIDS virus?

_____

_____

_____

_____

22. Would you say that:

		YES	NO	DON'T KNOW
1)	It's easy to get condoms?	___1	___2	___3
2)	Condoms can be fun or exciting to use?	___1	___2	___3
3)	It's hard to bring up the subject of condoms with your partner?	___1	___2	___3
4)	You're afraid of how your partner will react if you ask him or her to use a condom?	___1	___2	___3
5)	You find it easy to talk to your partner about other kinds of sex that are safer?	___1	___2	___3
6)	You're afraid of how your partner will react if you ask him or her to try some other kind of sex that is safer?	___1	___2	___3
7)	You find it hard to practice safer sex when you're sexually aroused?	___1	___2	___3
8)	You find it hard to practice safer sex when you're high on alcohol or drugs?	___1	___2	___3
9)	It's easy to get clean needles and syringes?	___1	___2	___3
10)	It's hard to convince your partner(s) to clean the needle and syringe before sharing it?	___1	___2	___3

23. Which of the following do you believe best describes your RISK of getting or spreading the aids virus?

1 ___ My behavior puts me at considerable risk of getting or spreading the AIDS virus.
2 ___ My behavior puts me at some of risk of getting or spreading the AIDS virus.
3 ___ My behavior puts me at very little risk of getting or spreading the AIDS virus.

24. Have you been in contact with any of the following agencies within the last 12 months for any reason?

		YES	NO
1)	A community AIDS organization	___1	___2
2)	A street program or talked to a street outreach worker	___1	___2
3)	An AIDS hotline	___1	___2
4)	A Health hotline	___1	___2
5)	An alcohol or drug treatment centre	___1	___2
6)	A birth control clinic or family planning service	___1	___2
7)	A doctor's office, or health clinic or service	___1	___2

25. Which of the following best describes your living situation? (*Check only one*)

1. ___ I live alone
2. ___ I live with my spouse/sexual partner
3. ___ I live with a friend or friends
4. ___ I live with my parent(s)
5. ___ I live in a group situation (*explain*) _____

26. Which of the following best describes where you live? (*Check only one*)

1. ___ Public housing
2. ___ Rented accommodation
3. ___ Self-owned home/condominium
4. ___ Temporary place like a hostel/shelter
5. ___ Homeless
6. ___ Other (*specify*) _____

27. Which of the following describes your principal sources of financial support? (*Check as many as apply*)

1. ___ Full time employment
2. ___ Part time employment
3. ___ Parents
4. ___ Spouse
5. ___ Student loan/scholarship
6. ___ Unemployment insurance
7. ___ Social welfare
8. ___ Savings
9. ___ Other (*specify*) _____

28. Which of the following best describes how you identify your ethnic background? (*Check only one*)

1. ___ French
2. ___ Ukrainian
3. ___ German
4. ___ Native Indian, Metis
5. ___ English
6. ___ Oriental
7. ___ East Indian
8. ___ Arab
9. ___ Other (*specify*) _____

29. What is the highest level of education you've completed? (*Check only one*)

1. ___ Some grade school
2. ___ Completed grade school
3. ___ Some high school
4. ___ Completed high school
5. ___ Some college or university
6. ___ Completed college or university
7. ___ Some graduate work
8. ___ Completed graduate work

30. How old are you? _____ (*Years*)

31. Are you male or female?

MALE ___1
FEMALE ___2

32. Have you ever been surveyed or interviewed about aids before?

YES ___1
NO ___2

33. Please use the back page if there is anything else you would like to say either about AIDS or this survey.

* * *

Thank you very much.

Your contribution to this study is very greatly appreciated.

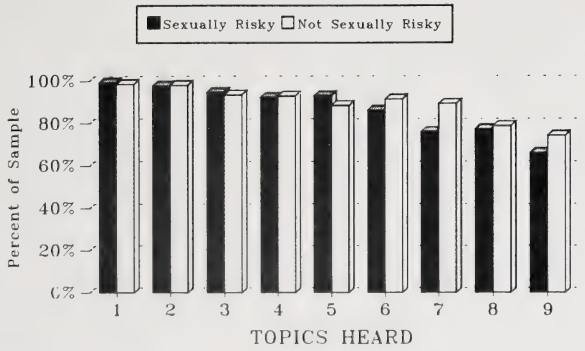
APPENDIX C

KEY FOR TABLES A1 - A4

TOPICS:

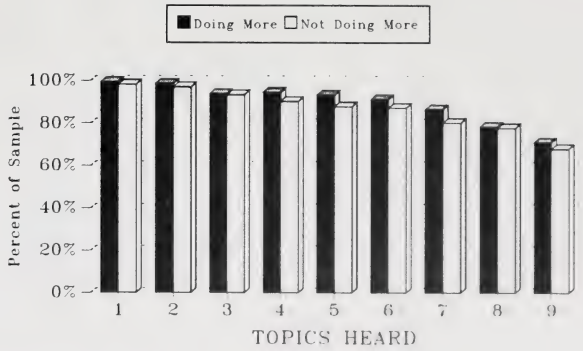
1. How the AIDS virus is spread
2. How some sexual activities can be made safer by using condoms
3. Sexual activities that are risky for getting or spreading the AIDS virus
4. How to convince your partner to use condoms
5. How likely it is for an infected mother or father to give the AIDS virus to their offspring
6. Testing for the AIDS virus and what it means if you test positive or negative
7. Different ways of having sex that are safer
8. Safer ways of injecting drugs
9. Ways to make safer sexual activities more erotic

FIGURE A1
SEXUAL RISK STATUS IN LAST 12 MONTHS



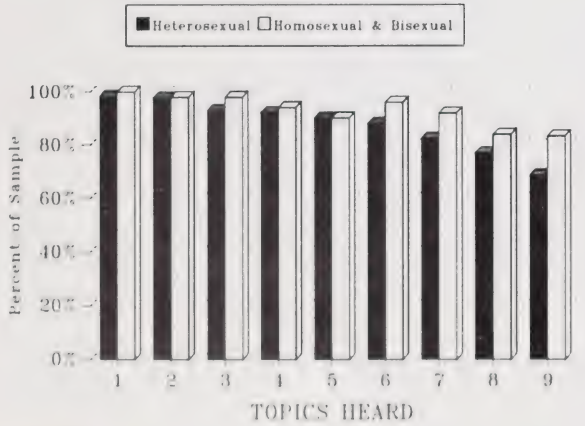
Topic numbers correspond to key on opposite page.

FIGURE A2
BEHAVIORAL CHANGE STATUS IN LAST 12 MONTHS



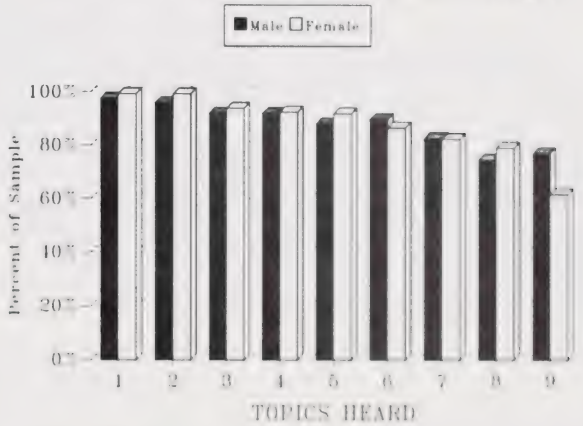
Topic numbers correspond to key on opposite page.

FIGURE A3
SEXUAL ORIENTATION



Topic numbers correspond to key on opposite page.

FIGURE A4
GENDER (Heterosexuals Only)



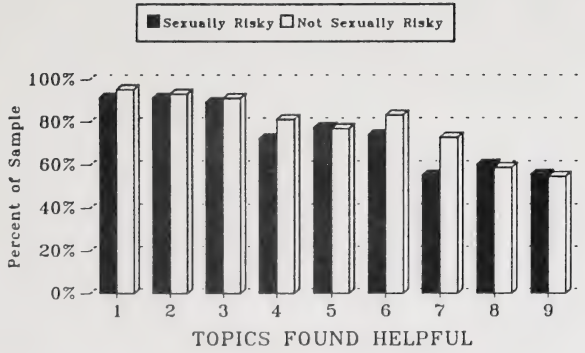
Topic numbers correspond to key on opposite page.

KEY FOR TABLES A5 - A8

TOPICS:

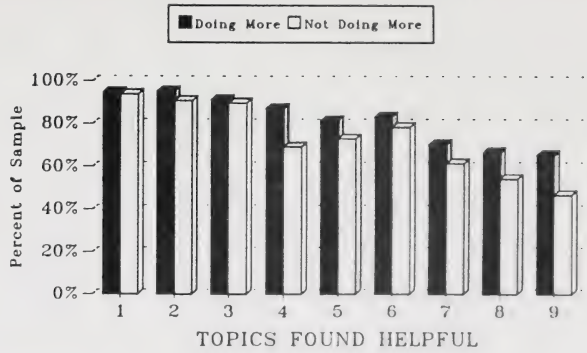
1. How the AIDS virus is spread
2. How some sexual activities can be made safer by using condoms
3. Sexual activities that are risky for getting or spreading the AIDS virus
4. How to convince your partner to use condoms
5. How likely it is for an infected mother or father to give the AIDS virus to their offspring
6. Testing for the AIDS virus and what it means if you test positive or negative
7. Different ways of having sex that are safer
8. Safer ways of injecting drugs
9. Ways to make safer sexual activities more erotic

FIGURE A5
SEXUAL RISK STATUS IN LAST 12 MONTHS



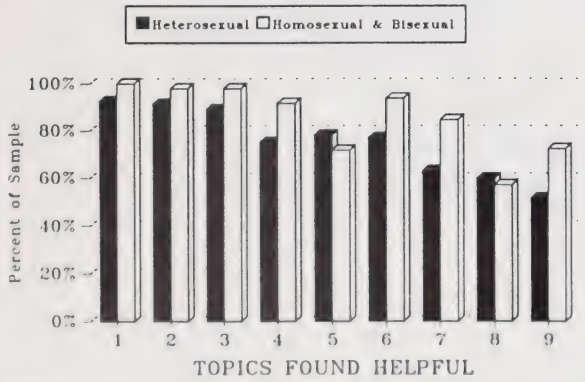
Topic numbers correspond to key on opposite page.

FIGURE A6
BEHAVIORAL CHANGE STATUS IN LAST 12 MONTHS



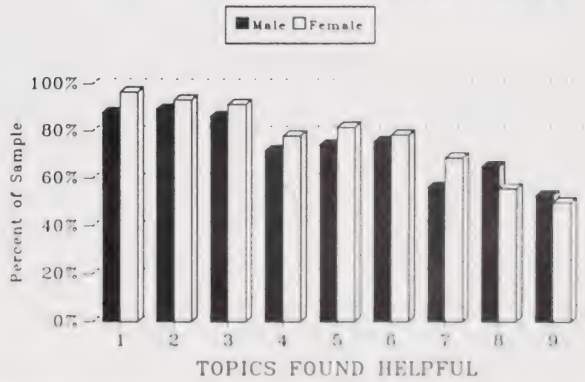
Topic numbers correspond to key on opposite page.

FIGURE A7
SEXUAL ORIENTATION



Topic numbers correspond to key on opposite page.

FIGURE A8
GENDER (Heterosexuals Only)



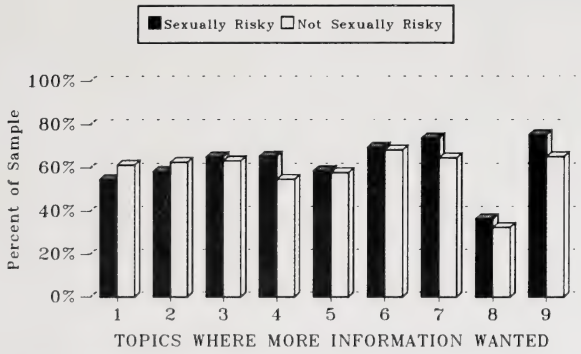
Topic numbers correspond to key on opposite page.

KEY FOR TABLES A9 - A12

TOPICS:

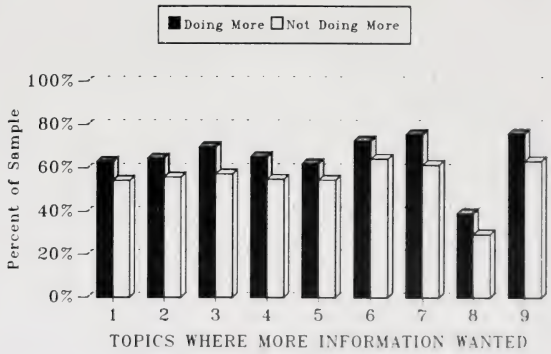
1. How the AIDS virus is spread
2. How some sexual activities can be made safer by using condoms
3. Sexual activities that are risky for getting or spreading the AIDS virus
4. How to convince your partner to use condoms
5. How likely it is for an infected mother or father to give the AIDS virus to their offspring
6. Testing for the AIDS virus and what it means if you test positive or negative
7. Different ways of having sex that are safer
8. Safer ways of injecting drugs
9. Ways to make safer sexual activities more erotic

FIGURE A9
SEXUAL RISK STATUS IN LAST 12 MONTHS



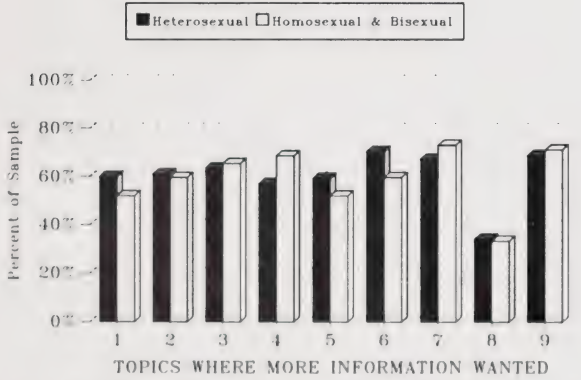
Topic numbers correspond to key on opposite page.

FIGURE A10
BEHAVIORAL CHANGE STATUS IN LAST 12 MONTHS



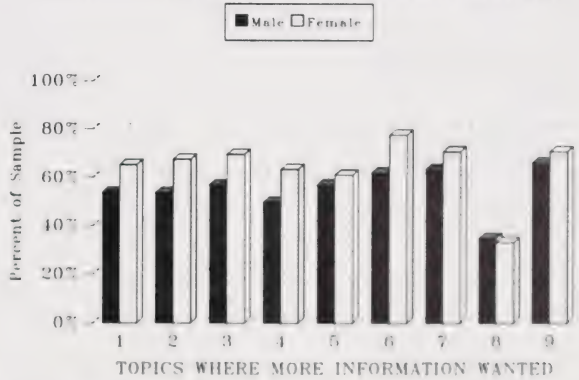
Topic numbers correspond to key on opposite page.

FIGURE A11
SEXUAL ORIENTATION



Topic numbers correspond to key on opposite page.

FIGURE A12
GENDER (Heterosexuals Only)



Topic numbers correspond to key on opposite page.

APPENDIX D

KEY FOR TABLES A13 - A16

BEHAVIORS:

1. Avoid risky drug injection practices
2. Generally look after your health better
3. Reduce the number of partners you have sex with
4. Avoid getting involved with people who are not concerned about safer sex
5. Avoid situations where you might be more likely to have casual sex
6. Use condoms during vaginal or anal intercourse in certain situations
7. Ask more questions about your partner's past sexual behavior
8. Practice other forms of sex (e.g., mutual masturbation) that are less risky
9. Always use condoms during vaginal or anal intercourse
10. Change your social or sexual behavior in some other way
11. Abstain from sexual intercourse altogether

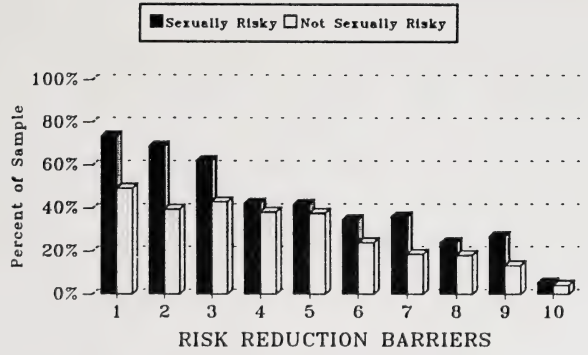
APPENDIX E

KEY FOR TABLES A17 - A20

BARRIERS:

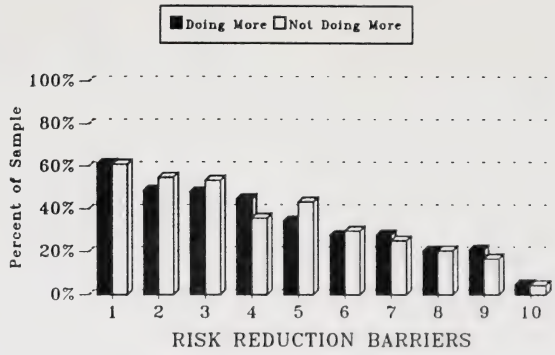
1. You find it hard to practice safer sex when you're high on alcohol or drugs
2. You find it hard to practice safer sex when you're sexually aroused
3. Condoms are not fun or exciting to use
4. It's hard to convince your partner(s) to clean the needle and syringe before sharing it
5. You find it hard to talk to your partner about other kinds of sex that are safer
6. It's hard to get clean needles and syringes
7. It's hard to bring up the subject of condoms with your partner
8. You're afraid of how your partner will react if you ask him or her to try some other kind of sex that is safer
9. You're afraid of how your partner will react if you ask him or her to use a condom
10. It's hard to get condoms

FIGURE A17
SEXUAL RISK STATUS IN LAST 12 MONTHS



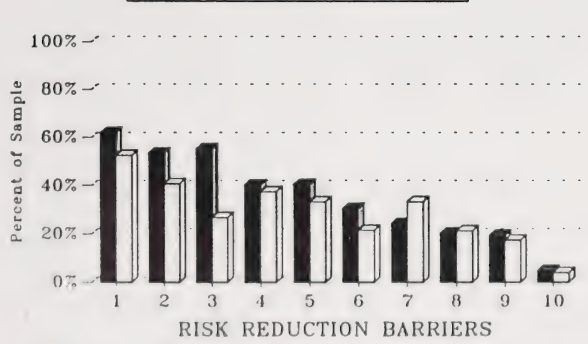
Barrier numbers correspond to key on opposite page.

FIGURE A18
BEHAVIORAL CHANGE STATUS IN LAST 12 MONTHS



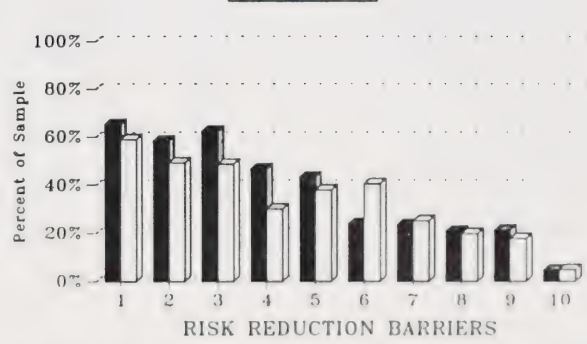
Barrier numbers correspond to key on opposite page.

FIGURE A19
SEXUAL ORIENTATION



Barrier numbers correspond to key on opposite page.

FIGURE A20
GENDER (Heterosexuals Only)



Barrier numbers correspond to key on opposite page.

APPENDIX F

FOCUS GROUP COMMENTS AND SUGGESTIONS

Homosexual Males

- Promote long-term relationships among homosexual men
- Place information in malls where young people hang out
- Make condoms more user friendly
- Condom ads should be as common as tampon/feminine protection ads
- All bars, peep shows and porn shops should give away free condoms
- Incorporate condom use into sex education in schools
- Messages should be hard-hitting, straight-forward and blunt e.g., the drinking and driving campaign
- Encourage businesses and other organizations, like the Alberta Government, to include HIV/AIDS information in employees' pay envelopes
- Make messages positive e.g., "have a good time having sex" rather than "watch out"
- Show people alternatives to unsafe sex for when they don't have a condom e.g., mutual masturbation
- Copy drug and alcohol ads e.g., "This is your brain...This is your brain on drugs"
- Should use appropriate humor, not just doom and gloom messages
- CRTC could regulate the portrayal of safer sex on television
- Put warnings about AIDS on condom, syringe and needle packaging
- Use more imagery
- Different messages for different age groups
- "Use an ounce of prevention because there is no cure"
- Show a hand holding a condom with the caption "nobody deserves to die"
- AIDS 1-800 numbers should be better advertised
- Should saturate the market with information and condoms
- Use more imagery - visual, audio, moving images
- Tap into people's emotions
- Build self-esteem among gay men so they care more about protecting themselves
- More education in schools - give them the skills to make safe decisions regarding sexuality (this would include all sexual orientations)
- Realistic messages e.g., "chances are that if you don't protect yourself, you will come in contact with HIV. It may not be tomorrow or even next year, but it will happen sooner or later" (i.e., a subliminal death sentence)
- Positive/fun messages e.g., the Participaction campaign
- Target messages specifically to the gay community

- Messages should be more blunt and graphic e.g., talk about "fucking" and "sucking" rather than anal and oral sex
- Use sexually implicit (vs. explicit) material i.e., erotic, not pornographic
- Use language people understand
- Use sexual imagery to sell safer sex as we do with other things like beer and cars
- Use positive role models for gay men - this will promote a positive gay image and this leads to safer sex practices
- Use a less clinical approach
- Use rock stars to talk about AIDS on Much Music
- Target different age categories - the under 25 group may be missing the information even from the gay community because so much of it is aimed at the age group that pre-dates the AIDS crisis
- "This is what you CAN do" as opposed to "This what you SHOULDN'T do"
- Encourage responsibility for the next generation e.g., campaign for "greening the world"
- Put safer sex posters and bowls of condoms in bars - "after dinner condom", "condom matchbooks"
- Portray a condom user as being much more attractive and appealing than a non-condom user
- Use peer pressure to encourage people to use a condom
- Pump messages into the mainstream
- Market safer sex as you would any other product
- Put free condoms in magazines
- Put messages on buses, billboards, cereal boxes, milk cartons
- Create condom "six packs"
- Use the PMA (Positive Mental Attitude) approach - combine positive messages about being gay with messages about safer sex

Heterosexual Males

- Televise programs that graphically illustrate people with AIDS i.e., shock people (fact can sometimes be scarier than fiction)
- Use condoms in beer ads or format AIDS ads more like beer commercials
- Give away free condoms in bars, colleges, schools, clinics, on the street (i.e., huge influx of condoms into the province to heighten public awareness)
- Compare the costs of massive condom distribution with the health care costs for an AIDS victim
- Show people with AIDS that we all know e.g., Magic Johnson

- Make condom ads more fun and erotic e.g., whipped cream and cherries(should think of condoms as a sexual aid rather than protection, they should be viewed as enhancing sexuality, not inhibiting it)
- Movies and television shows should portray the use of condoms
- Pornography should show the use of condoms
- Ads for safer sex should be more graphic/explicit i.e., with sexual connotations, not necessarily pornographic
- "AIDS can happen to anyone at any time"
- "You're going to die if you get AIDS"
- "There are no second chances"
- "Don't let the wrong head do the thinking"
- Messages should be more direct, explicit, emotional, honest, open
- Put condoms out in the open in bars
- Put condom machines in schools
- People who are well known and test positive for HIV convey the message better than others
- Use more personal statistics e.g., how many in my school/community tested positive for HIV?
- Should use layman/street talk to "hook" people
- Show people with full blown AIDS
- Target specific populations i.e., men, women, gays, straights, young, old
- Use personal stories from jocks, businessmen, housewives, etc.
- Show that condoms are effective so that people will be more confident using them
- Tell people what to be afraid of and how they can deal with that fear
- Show people how to use condoms - they are unsafe when misused
- Messages should be in schools, bars and public washrooms; on buses, billboards posters and television
- "You could be next"
- "You have an X% chance of getting AIDS"
- "You could have AIDS"
- "Don't just try---PRACTICE safer sex"
- "Every time you have sex, it's like putting a gun to your head with one bullet in it and pulling the trigger"
- "Sex without condoms is better" -- Then show someone who is dying from AIDS saying, "Yeah, it's way better"
- Copy the "I told two friends" campaign --- "I slept with two friends and they slept with two friends and so on and so on and so on"

Heterosexual Females

- Make the language simpler, less "medical"
- Show a healthy woman saying "I didn't think I would get it"
- Show people in the final stages of AIDS - especially a middle class woman
- Movies and television need to deal with women and AIDS more
- Pamphlets should be more visual, brighter and more pleasing to the eye
- Help women to understand that it is their responsibility to carry and use a condom
- Show women that they can get AIDS from a "nice guy" and that short term monogamy does not make you safe
- Information should be placed in magazines, Doctors' offices, health clubs, women's washrooms, churches, women's organizations, shelters and treatment centers
- Air television ads during soap-operas or talk shows
- Conduct AIDS awareness workshops in the work place as part of health and safety programs
- Target messages specifically at women
- Make the message more emotional - show the pain of AIDS (victim, family and friends)
- Use simple statistics e.g., 1 in every 5 families
- Educate Doctors i.e., they often dismiss a woman's concern that she may have been infected
- Show before and after pictures of a woman with AIDS
- Use age appropriate role models as spokespersons e.g., female rock stars, business women, housewives
- Use appropriate humor e.g., in a cartoon strip like "For Better or Worse"
- "My definition of a loser is someone who doesn't have a condom at the end of the night"
- Market condoms more towards women e.g., door to door condom sales (Japan)
- Put condoms in bars
- "Is your life worth a dollar" - sign on a condom machine
- Give free condoms to low income and street people
- Condoms should be in school washrooms as well as a part of sex education classes i.e., how to use condoms and make them fun and erotic
- "Candid condom comments"
- Use irony/black humor e.g., This is your brain....AADAC
- Use strong campaigns similar to drinking and driving campaigns - must target people when they are sober
- Make condoms more accessible - they have to become second nature

- Monogrammed condoms, condom key chains, condom matchbooks
- Put condom machines everywhere
- Help women help themselves
- Magic Johnson showed that anyone can get it
- Try and reach church leaders so they can educate their own
- A cabaret gives out free condoms - this helps to educate people
- Sleeping around does not give you AIDS - it only takes one partner
- Big basket of condoms at the U of L - very positive message
- U of Ottawa "hear no evil, see no evil, do no evil" - very visual
- Female speakers telling their personal stories work better than clinical health care professionals
- Show photos of people dying of AIDS
- Make the messages open, frank and explicit
- Put messages on billboards and buses
- More family education
- Make up some radio jingles and commercials e.g., Aretha Franklin song "Respect Yourself" changed to "Protect Yourself"
- Teach women to be responsible for their own protection i.e., that it is acceptable to use condoms and acceptable to say no if your partner doesn't want to use one
- Mirror non-drug/smoking campaigns "be cool, be smart...use a condom"
- Women ages 26-36 become more assertive - mold advertising toward that behavior
- AIDS messages should be for married and single people i.e., some people stop using condoms when they get married, however the risk is still there (if HIV+ before marriage, then HIV+ after marriage - there is also the question of fidelity in marriage
- Need to legitimize condoms and make them more positive, glamorous and fun to use
- Market condoms as a must, not a choice
- Associate condoms with love and caring
- A HE-MAN ad "I'm always prepared"
- Attack the belief system - make it socially unacceptable to have unsafe sex/sex without a condom
- Put condoms in "college kits"
- Make condoms available in hotels as they do with other samples i.e., soap, shampoo, mints
- Promote condoms as birth control
- Promote an overall healthy lifestyle that includes safer sex

- Make condoms a status symbol e.g., show a woman buying condoms, and a guy comes up and thinks "Well, here's a woman who looks after herself" - that makes her appealing to him
- "You've come a long way baby" - from being embarrassed to buy a condom, to freely accessing condoms
- Use "infomercials" or the home shopping network to sell condoms
- Provide product control of condoms to make sure they are safe i.e., do not allow novelty items on the market
- Need to cross cultural and religious barriers
- Which is worse, being embarrassed buying condoms, or dying from AIDS?
- "It's no longer an option...It's a matter of life"
- Must overcome the stigma of AIDS - should canvas door to door like other organizations
- To parents "are you willing to risk your child getting AIDS?" i.e., use fear or guilt to try and reach more conservative parents
- "Suzy, aged 15, has just gone on her first date with Johnny. Suzy probably won't live to see the age of 19 because Johnny gave her AIDS"
- Simple sign on a condom machine "Is your life worth a dollar"
- Make pretty compacts for condoms
- Base a campaign on "sex police" or "designated condom man"